Partnership *for* Health

A Brief Safer Sex Intervention for HIV Outpatient Clinics

Technical Assistance Guide

PARTNERSHIP FOR HEALTH:
A Brief Safer Sex Intervention for HIV Outpatient Clinics

Important Information for Users

This HIV/STD risk-reduction intervention is intended for use with persons who are at high risk for acquiring or transmitting HIV/STD and who are voluntarily participating in the intervention. The materials in this intervention package are not intended for general audiences.

The intervention package includes implementation manuals, training and technical assistance materials, and other items used in intervention delivery. Also included in the packages are: 1) the Centers for Disease Control and Prevention (CDC) fact sheet on male latex condoms, 2) the CDC Statement on Study Results of Products Containing Nonoxynol-9, 3) the Morbidity and Mortality Weekly Report (MMRW) article "Nonoxynol-9, Spermicide Contraception Use—United States, 1999," 4) the ABC's of Smart Behavior, and 5) the CDC guidelines on the content of HIV educational materials prepared or purchased by CDC grantees (Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in CDC Assistance Programs).

Before conducting this intervention in your community, all materials must be approved by your community HIV review panel for acceptability in your project area. Once approved, the intervention package materials are to be used by trained facilitators when implementing the intervention.

The CDC requires all CDC-funded agencies using the Partnership for Health intervention to identify, or establish, and utilize a Program Review Panel and complete Form 0.1113 to document this activity. Partnership for Health and University of Southern California staff members are not involved in this activity. This is a CDC requirement for their grantees, and all questions in this regard should be directed to your agency's CDC Project Officer or to the health department funding your agency's implementation of Partnership for Health.

Filling out CDC Form 0.113 for Written Educational Materials on HIV/AIDS

In conjunction with the Centers for Disease Control and Prevention's (CDC's) efforts to increase awareness and use of evidence-based effective HIV prevention interventions, we are distributing copies of CDC form 0.113 (see attached). The following provides rationale and instructions on how to complete form 0.113.

Form 0.113 asks you to list the names and other identifying information for the individuals who make up your Program Review Panel. A Program Review Panel is a group of at least five people, representing a cross section of the population in a given area, who review written materials intended for HIV/AIDS educational programs. The Program Review Panel represents local standards and judgment as to what materials are appropriate for selected local audiences.

Should you need to form a Program Review Panel, see CDC's "Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs (Interim Revisions June 1992)." Following are a few key points from that document:

- Written educational materials on HIV prevention should use language or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices regarding HIV transmission.
- Such materials should be reviewed by a Program Review Panel.
- Whenever possible, CDC-funded community-based organizations (CBOs) are encouraged to use a Program Review Panel formed by a health department or other CDC-funded organizations rather than establish a new one.

To complete the enclosed form 0.113:

1. List the name, occupation, and affiliation (organization, business, government agency, etc.) of each member of the Program Review Panel you are using. There must be at least five members of this panel. If there are more, list them on the back of the form.
2. List the name of your organization, your grant number (if known), and ensure the form is signed by both your project director and an authorized business official. Have each person date the form after signing it.
3. If you are not developing any new HIV/AIDS related materials and therefore do not need to use a Program Review Panel, complete the second page, "Statement of Compliance with Content of HIV/AIDS-Related Written Materials, Pictorials, Audiovisuals, Questioners, Survey Instruments, and Educational Sessions." This states that your organization is using materials previously approved by the local Program Review Panel.

Please note that form 0.113 is currently undergoing revision. The revised version will soon be available. A key change in the new form is that is requires, rather than recommends, that CBOs use the Program Review Panel established by the local or state health department rather than forming a new one. Please contact us if you have questions or need technical support.

Once you have completed form 0.113, please return it to your Project Officer or maintain it in your files if you are not directly funded by CDC.

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

ASSURANCE OF COMPLIANCE
with the
"REQUIREMENTS FOR CONTENTS OF AIDS-RELATED WRITTEN MATERIALS, PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY INSTRUMENTS, AND EDUCATIONAL SESSIONS IN CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) ASSISTANCE PROGRAMS"

By signing and submitting this form, we agree to comply with the specifications set forth in the "Requirements for Contents of Aids-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs," as revised June 15, 1992, 57 Federal Register 26742.

We agree that all written materials, audiovisual materials, pictorials, questionnaires, survey instruments, proposedgroup, educational sessions, educational curricula and like materials will be submitted to a Program Review Panel.The panel shall be composed of no less than five (5) persons representing a reasonable cross-section of the general population; but which is not drawn predominantly from the intended audience. (See additional requirements in attached contents guidelines, especially paragraph 2.c. (1)(b), regarding composition of Panel.)

The Program Review Panel, guided by the CDC Basic Principles (set forth in 57 Federal Register 26742), will review and approve all applicable materials prior to their distribution and use in any activities funded in any part with CDC assistance funds.

Following are the names, occupations and organizational affiliations of the proposed panel members: (If panel has more members than can be shown here, please indicate additional members on the reverse side.)

NAME	OCCUPATION	AFFILIATION
		(Health Department Representative)

Applicant/Grantee Name

Grant Number (If Known)

Signature: Project Director

Signature: Authorized Business Official

Date

Date

Partnership for Health
Brief Safer Sex Intervention for HIV Outpatient Clinics

Technical Assistance Guide

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Partnership for Health is a program of the
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at the University of Southern California

A Clinician's Guide for
Use with Patients Living with HIV
To Protect Their Health and
To Prevent HIV Transmission

This Technical Assistance Guide is provided through funding from the Centers for Disease Control and Prevention's Replicating Effective Programs (REP) project, cooperative agreement # U65/CCU92-2095.

This program was developed by the Institute for Health Promotion and Disease Prevention Research and the Department of Preventive Medicine at the University of Southern California supported by grant # R01 MH 57208 from the National Institute of Mental Health. Additional support was provided by the Pacific AIDS Education and Training Center at the University of Southern California and by grant # CC99-SD-003 from the University-wide AIDS Research Program to the California Collaborative Treatment Group.

Partnership for Health Technical Assistance Guide
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Introduction

About 70% of HIV-positive patients are sexually active, and about one-quarter to one-half of them engage in unprotected sexual behaviors and are possibly transmitting the virus to others. HIV prevention involves a number of strategies to help people learn their status and to avoid acquiring HIV, but if we are to prevent the spread of HIV/AIDS, we must work with HIV-positive persons to decrease their rates of unsafe sex. Providers of HIV medical care are in the best position to speak regularly with their patients about safer sex and disclosure of HIV status. However, few providers regularly include prevention counseling as part of their practice.

The HIV outpatient clinic is an ideal setting to:

- reach a large number of HIV-positive persons who regularly visit the clinic for treatment and primary care;
- implement a safer-sex prevention program to motivate HIV-positive persons to protect themselves and their partners by reducing risk behaviors;
- integrate prevention within routine medical care; and
- involve clinic staff especially physicians, physician assistants, nurse practitioners, nurses, and counselors in prevention counseling.

The Partnership for Health intervention is a brief interaction between the patient and provider, and it includes:

- prevention as an essential component of routine clinic care;
- having the medical provider establish a partnership with the patient and reinforce the prevention messages and recommendations during the patient's medical visits;
- printed information (posters, brochures, and patient education materials) that introduces the patient to the partnership concept and specific information about the importance of safer sex.

Section 1. How to Use This Guide

The Technical Assistance Guide is a resource for clinic administrators and technical assistance (TA) providers to provide guidance regarding clinic-level logistics required for the implementation and integration of PfH. It is a companion to the Participant's Manual which presents information about the intervention. With this manual and guide, clinics will be prepared to implement the PfH as part of their standard of care.

This guide contains the following:

- **Section 2:** Outline of materials in the PfH Package.
- **Section 3:** CDC's national strategy to make effective HIV behavioral interventions available to communities. This section also presents information about the science behind PfH.
- **Section 4:** A description of the PfH intervention and provides important information regarding PfH Core Elements.
- **Section 5:** The "how-to" of integrating PfH into the clinic setting— staffing, costs to clinic, implementation steps and timelines.
- **Section 6:** Estimated cost-savings resulting from PfH in terms of the cost of averting a new infection.
- **Section 7:** Information about adapting and tailoring PfH to meet the clinic and patient population needs with fidelity to PfH Core Elements.
- **Section 8:** Program evaluation, evaluation tools, and instructions for use.
- **Section 9:** A checklist for clinic administrator(s), on-site PfH coordinators (Coordinators), and key leaders to answer a series of questions to determine whether the PfH program is appropriate for the clinic setting.
- **Section 10:** Contact information for the PfH research team at the University of Southern California and your local PfH trainer/Technical Assistance (TA) provider.

Partnership for Health Technical Assistance Providers. Technical assistance for Partnership for Health (PfH) will be provided by the PfH trainers from AIDS Education and Training Centers (AETC).

Section 2. What is in the package

2.1 The PfH Intervention Package

The PfH package provides comprehensive materials to support and increase skills of health care providers to:

- talk with patients about the partnership theme and the importance of safer sex and disclosure of HIV status,
- use the supporting materials,
- respond to challenging questions from patients, and
- to make immediate and appropriate referrals.

The ultimate goal is to decrease unsafe sexual behaviors among HIV positive patients.

2.2 Contents of the intervention package

- Technical Assistance Guide
  - A resource for clinic administrators and TA providers to give guidance regarding clinic-level logistics required for implementation and integration of PfH.
- Participant Training Manual for each provider
  To guide clinics through the planning, implementation, and maintenance of the intervention. The manual includes sections on:
  - Study results, justification and background
  - Overview of intervention materials
  - Communication skill building
  - Initiating appropriate discussions about sex with patients
  - Message framing
  - Role-play exercises to integrate PfH skills
- Written materials
  - Posters for hallways and waiting rooms
  - Brochures about PfH and prevention themes
  - Informational flyers for patients
    - Each flyer addresses one topic or issue
    - Designed to alternate monthly for on-going patient education
  - Provider pocket counseling guide
  - Medical chart sticker to document the intervention
- Videos
  - Marketing video explaining the PfH program and its benefits
  - Training video demonstrating patient-provider PfH interaction

Section 3. Science-Based Interventions

3.1 CDC diffusion of science-based interventions

The Centers for Disease Control and Prevention (CDC) has a national strategy to provide high quality training and technical assistance to prepare regional and community HIV programs to implement science-based HIV interventions. The CDC is collaborating with the original researchers to make effective interventions available to communities.

For information about other effective interventions being diffused through CDC, visit the CDC websites:
www.cdc.gov/hiv/partners/ahp.htm
www.cdc.gov/hiv/projects/rep/default.htm
www.effectiveinterventions.org

3.2 Diffusion of the Partnership for Health Program

The Partnership for Health is one of the effective interventions being diffused nationally by the CDC. Using a train-the-trainer model, the PfH program provides training to a network of trainers who will then train health care providers in HIV clinics. Train-the-trainer sessions will be delivered to trainers from AETCs, who will train providers at county and state health departments, university-based health care facilities, other public and private health care delivery systems, and Veterans' Administration facilities.

3.3 The Science Behind PfH

The PfH program is the product of extensive collaboration among researchers and people living with HIV (PLWH), clinics and health care providers who have implemented the intervention. The PfH was empirically tested at six HIV outpatient clinics with funding from the National Institute of Mental Health (NIMH). The PfH intervention package has also been field-tested in an additional five medical clinics and one HIV/AIDS community-based organization as part of the CDC Replicating Effective Programs (REP) project.

Partnership for Health (PfH) is a brief, provider-delivered counseling program for men and women receiving medical care in the HIV clinic setting. The program is designed to improve patient-provider communication about safer sex and disclosure of HIV serostatus. It is based on a social cognitive model that uses message framing, repetition, and reinforcement to increase the patient's knowledge, skills and motivations to practice safer sex and disclosure.

The PfH study tested the effectiveness of a brief safer sex intervention delivered by health care providers to sexually active HIV positive patients in six HIV clinics in California. Study clinics were randomly assigned to one of three conditions, and all patients received the intervention to which their clinic was assigned. Patients at two clinics assigned to the advantages frame condition received advantages frame safer sex counseling. Advantages frame messages focus on a positive outcome that may happen or a negative result that may be avoided when the patient engages in safer sexual behaviors or discloses his or her serostatus to sex partners. Patients at two clinics assigned to the consequences frame condition received consequences frame safer sex counseling. Consequences

frame messages emphasize a positive outcome that may be missed or a negative result that may occur when the patient engages in unsafe sexual behaviors or does not disclose his or her serostatus to sex partners. Patients in the clinics assigned to the attention-control condition received an intervention addressing adherence to medication. (Please see Appendix A for more information about the Partnership for Health study design, methods, and findings.)

At baseline one third of the sexually active HIV positive people interviewed had unprotected anal or vaginal sex (UAV) with at least one partner during the previous three months.

- Of those with one sex partner, 26% had unprotected anal or vaginal sex.
- Of those with only one partner who was HIV negative, 20% engaged in unsafe sex.
- Half of those with two or more partners had unprotected anal or vaginal sex.

<u>Major PfH Study Results</u>:

At follow-up, the PfH study found that consequences frame safer sex messages were more likely than advantages frame messages to be effective in changing sexual behavior among persons who engaged in sexual behaviors likely to transmit HIV. The consequences frame intervention was effective in reducing unsafe sex among persons who had 2 or more partners.

- **There was a 38% reduction in unprotected anal or vaginal sex among persons who had two or more partners.**
- **The consequences frame intervention was also effective in reducing unsafe sex among persons who had casual partners.**
- **Neither frame was effective in reducing unsafe sexual behaviors among persons with only one main partner.**

3.4 Consequences frame or advantages frame with HIV positive patients?

For HIV positive persons with multiple and/or casual partners or who have unsafe sex

- Consequences frame messages can be effective in reducing UAV in this group.
- Consequences frame messages emphasize the negative consequences that may occur or the positive outcome that may be missed when the patient engages in unsafe sexual behaviors or does not disclose his or her serostatus to sex partners.
- Consequences frame messages link a patient's actual behavior with a negative outcome.

For HIV-positive persons who are abstinent or practice safer sex with one main partner

- It is not clear which frame messages are effective with persons who engage in low risk behavior or persons who are abstinent in order to maintain low risk behaviors.
- Advantages frame messages focus on a positive outcome that may happen or a negative result that may be avoided when a patient engages in safer sexual behaviors or discloses his or her serostatus to sex partners.
- Abstinent or completely safe behaviors are effective in preventing HIV transmission and should be reinforced.
- Associating positive outcomes with these low risk (safer sex with one partner) or no risk (abstinence) behaviors may reinforce continued low risk behaviors.

3.5 Commonly Asked Questions

1) **Why is it important for the medical provider to deliver the message?**
Many studies show that provider counseling can have a beneficial effect on patient self-care behavior for a variety of health conditions. Information from the medical provider carries more weight and is attended to by patients. The medical provider plays a significant role in an HIV-positive person's life and, therefore, needs to be actively involved in prevention efforts. The PfH research demonstrated that how a provider delivers a message to a patient can make a difference in the patient's perception of the seriousness of his or her behaviors and decision to change behavior to protect him or herself and his or her sexual partners.

2) **Why is the consequences frame message more effective with higher risk HIV-positive patients than advantages frame messages?**
Though we are not certain, a few possible explanations are:

- When people have a serious illness, the potential costs or consequences of actions that could cause that disease to become worse may be particularly salient. This may increase motivation for self-protective behavior.
- Consequences frame messages delivered by a highly credible source such as a health-care provider to a patient who has heightened concerns about his own health may be particularly powerful and may strongly capture his attention, increasing the extent the message is psychologically processed and acted upon.
- Consequences frame messages may have more of an emotional impact than advantages frame messages for the higher risk PLWH.
- Consequences messages may appear to be more to the point and serious than advantages framed messages.
- Consequences frame messages may be the customary way for providers to interact with patients and may be the expected norm in the health care setting.
- Consequences messages may be consistent with the patient's own perceptions and values, that is, very few patients actually want to infect another person. Consequences frame messages may be more likely to evoke the serious concern that he actually could infect another person and having a provider who states this directly may stimulate a thoughtful reconsideration of these serious concerns
- The consequences-frame points out the potential serious consequences of the high-risk patient's current behavior while the advantages-frame addresses potential benefits of changed or idealized behavior. Thus the high risk patient may more easily identify with the consequences frame messages.

3) **How are consequence frame messages different from negative messages or "scare" tactics?**

    - Consequences frame messages present the most at-risk patients with realistic outcomes that may result from their actual behaviors.
    - Scare tactics exaggerate the situation and therefore are difficult for the patient to take seriously.
    - Consequence framing directly and honestly links risky behaviors with realistic consequences or outcomes.

Section 4: Partnership for Health Intervention Description

4.1 Brief Description

At clinics providing primary medical care to HIV-positive persons, patients are given an informational flyer (in English or Spanish) at the front desk. Posters calling attention to the importance of patient-provider teamwork are displayed in the waiting room. After the physical exam, the medical provider conducts the 3- to 5-minute counseling session. The provider delivers messages that focus on self-protection, partner protection, and disclosure. The provider frames the messages relative to the number and type of sex partners the patient has and whether the patient is practicing safe or unsafe sex. Consequences-framed messages emphasize a positive outcome that may be missed or a negative result that may occur when the patient engages in unsafe sexual behaviors or does not disclose their serostatus to their partners. Advantages-framed messages focus on a positive outcome that may happen or a negative result that may be avoided when the patient engages in safe sexual behaviors or discloses their serostatus to partners. Consequences-framed messages were shown to be more effective in reducing unprotected anal or vaginal sex among HIV-positive patients with multiple or casual partners. The provider uses the brochures, informational flyers and posters in the examination room to facilitate counseling. The provider and patient identify behavioral goals for the patient to work on. The provider gives the patient referrals to services if any are needed. At follow-up visits, the provider inquires about the patient's progress on the behavioral goal, re-counsels the patient, and reinforces the patient's healthful behavior.

4.2 PfH Goals

- To train health care providers and staff in HIV outpatient clinics to talk with their patients about the importance of protecting themselves and their sex partners and disclosing their HIV status to sex partners before having sex with them.
- To improve patient and provider communication about safer sex and disclosure.
- To decrease unsafe sexual behaviors among persons living with HIV.
- To increase disclosure of HIV status to sex partners.

4.3 Core health education/risk reduction messages

<u>For the provider</u>

- Use consequences frame messages with higher risk HIV-positive patients
- Use either frame with lower risk HIV-positive patients
- Reinforce safer behavior with all patients

<u>For the patient</u>

- Protect yourself
- Protect your partner
- Disclose your serostatus appropriately*
    - *It is important that the HIV positive person disclose his or her HIV status appropriately, keeping in mind several factors: such as: personal safety, disclosing on a need to know basis, and disclosing before having sex. There may be other family or personal considerations when disclosing one's HIV status. Please see Module 6 in the Participant's Manual for more information about disclosure.

4.4 Core elements and key characteristics

Core elements are intervention components that must be maintained without alteration to ensure program effectiveness. There are nine core elements for the PfH.

- Having providers deliver the intervention to HIV-positive patients in HIV outpatient clinics.
- Having the clinic adopt prevention as an essential component of patient care.
- Training of all clinic staff to facilitate integration of the prevention counseling intervention into standard practice.
- Using waiting room posters and brochures to reinforce prevention messages delivered by the provider.
- Building on the ongoing supportive relationship between the patient and the provider.
- During routine visits, having the provider initiate at least a 3 to 5-minute discussion with the patient or client about safer sex that focuses on self-protection, partner-protection, and disclosure.
- Having the provider incorporate good communication techniques and use of consequences-frame messages for patients or clients engaged in high risk sexual behavior.
- Providing referrals to needs that require more extensive counseling and services.
- Integrating the prevention message into clinic visits so that every patient is counseled at every visit.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. The key characteristics of PfH include:

- Training for all clinic staff should include information on the use of open-ended questions, demonstrating empathy and remaining non-judgmental.
- Counseling sessions can last longer than 5 minutes and follow-up reminders may last less that 3-5 minutes depending on the needs of the patients. It is important to repeat the message over time.
- Clinics should make condoms available in a way that patients can feel comfortable taking them as needed.

4.5 Intended patient population

The intended patient population is HIV-positive men and women who receive care at HIV clinics.

- **Patient sexual risk behaviors to be intervened upon**
  - Multiple sex partners.
  - Casual sex partners.
  - Unsafe sexual behaviors.
  - Unsafe sex with at-risk partners (i.e., HIV-negative partners or partners of unknown serostatus).
  - Non-disclosure of HIV status to sex partners prior to sexual relations.
    - Please see Module 6 in the Participatn's Manual for more information about disclosure.

4.6 Intended training population

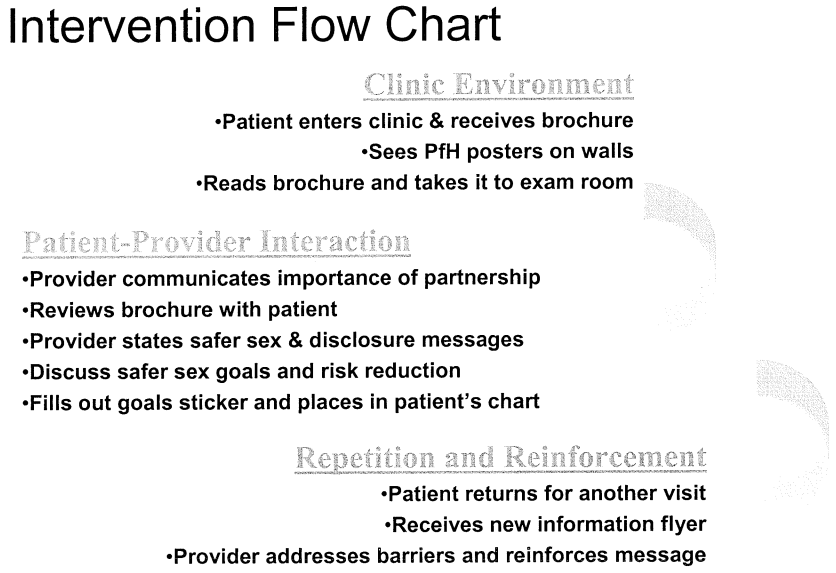
The intended population to be trained to deliver PfH is health care providers and staff in the HIV clinic setting.

- **Health care provider prevention strategies to be incorporated into clinic visit**
  - Initiate or increase interactions with patients to explore
    - Number of sex partners
    - Type of sex partners (main, casual)
    - HIV status of sex partners
    - Safer and unsafe sexual behaviors
    - Importance of patient self-protective sexual behavior
    - Importance of partner-protective sexual behavior
    - Importance of disclosure of HIV status to sex partners

4.7 Intervention flow and elements

The following chart illustrates the flow of the PfH intervention

1) PfH messages incorporated in the clinic environment;
2) patient-provider interaction;
3) repetition and reinforcement at subsequent clinic visits.



4.8 Provider brief counseling outline

Core health education and risk reduction messages are presented below:

Provider Brief Counseling Outline

1. Explain what the Partnership for Health is.

"The Partnership for Health is a program where healthcare providers and patients, like you and me, team up to keep you and your sex partners healthy. At our clinic, we are talking with all of our patients about safer sex. It is not easy to talk about sex, but it is important. I want to spend a few minutes talking with you about these issues, if that is OK with you."

2. Ask one or two questions about your patient's sexual behaviors and/or disclosure. Ask about problems they are having staying safe.

A. Reinforce any protective behavior

B. Understand the problem presented and identify it for the patient

3. Discuss some or all of the following three messages. Use consequences frame for patients who engage in high risk behaviors.

If patient is having unsafe sex or has many partners or casual partners, use consequences frame	If patient is completely safe with one partner or is abstinent, ...
Protect yourself. *If you don't use a condom, you risk picking up other sexually transmitted infections.*	Clarify what he or she means by safe or abstinent. *So, then, you haven't had <u>any unprotected sex</u> including oral, anal or vaginal sex with anyone in the last three months?*
Protect your partner. *If you have many casual partners and don't use protection, they might get the virus from you.*	Reinforce protective behavior. *Not having any unprotected sex is a good way to protect yourself and others.*
Talk to all your sex partners about your HIV status. *If you don't tell your sex partner you have HIV and he or she finds out later or gets infected, it could be much worse.*	Discuss what to do if he or she becomes sexually active in the future. *If you meet someone and decide to have sex in the future, it's crucial to use condoms to protect you and your partner's health.*

4. Set behavioral goal(s) with the patient or suggest some ideas if the patient cannot think of any. Remember small goals are important steps to staying safe.
Make a notation in the chart that safer sex counseling was done and note the goals to review at the next clinic visit.

5. Ask if there are questions and provide referrals if needed.

6. Deliver a supportive message, encouraging the patient to work on the goals and check in with you at the next visit.

4.9 Commonly Asked Questions

1) **Why does the entire clinic need training?**
Although the primary care provider is key to the delivery of the intervention, Partnership for Health is most successful when the clinic norms change to help support patients in their efforts to practice safer sex and disclosure. This shift in norms requires that all staff understand the messages the providers are giving patients and do what they can, in the context they can, to support the work of the provider. Also, often times in clinics, patients develop relationships with staff in addition to the medical provider. Training the entire clinic gives all of the staff tools and opportunity to reinforce the Partnership for Health program with patients.

2) **How are HIV health care providers using this model and what are their experiences?**
In general, clinicians reported that the counseling was extremely useful in opening up their communication with patients. Many reported that using PfH broadened their discussion and increased trust and frankness when communicating with patients about sexual practices and disclosure. Most providers felt that the program gave them a counseling strategy that was easy to incorporate into a clinic visit.

3) **We have many kinds of posters and patient educational materials at our clinic already. How are PfH materials different?**
The Partnership for Health posters, brochures and informational flyers were especially designed as a package to complement provider counseling with patients. These materials were designed to address three key points with patients: self-protection, partner-protection, and disclosure of serostatus to sex partners.

4) **Is it necessary to use all of the materials (posters, brochures, patient informational flyers)?**
PfH program materials were developed to be used as a package. Posters, brochures and patient informational flyers complement one another and support the PfH patient-provider relationship. It is important that the posters, brochures, and flyers be used as described. However, your clinic may wish to develop additional patient informational flyers to address the needs of your patient population. We encourage you to do so; you may wish to discuss this with your TA provider. (Please see the PfH materials in the Participant's Manual.)

5) **How do patients respond to this intervention?**
In the initial PfH research and subsequent diffusion, the majority of patients surveyed wanted to discuss safer sex and disclosure concerns with providers and felt comfortable doing that. In general, patients feel that these conversations are easier when the provider is nonjudgmental and able to listen to their concerns. Some patients felt that having such discussions with medical providers gave them more accurate information why and how they need to protect their own health as well as that of their partner(s). Some patients reported they felt that talking with their provider about their sexual practices helped the provider to better understand them and to better address the patient's overall health.

6) **How does PfH address patient substance use or abuse?**
Substance use can have a strong impact on sexual behavior. Although PfH specifically addresses sexual behavior, there are many materials available to address substance use. This material can be used as a tool to assist providers in their discussion with patients about substance use and to provide patients with appropriate information using the PfH model and loss frame messages. It is wise for providers to have a good referral system for their patients who have problems with alcohol and other drugs. These are long term and difficult issues and require more intensive counseling.

7) **What are some of the issues I need to consider when addressing disclosure with a patient?**
Since the earliest days of the epidemic, disclosure of HIV status has been recognized and endorsed in terms of a partner's right to know. This is an issue that relates to the rights of partners to make informed decisions about their own sex life and their own health and should be encouraged. Nevertheless, some patients find it harder to disclose to a new partner than to suggest that they use a condom.

Nondisclosure is more likely to occur when patients have more than one partner and when patients have casual partners. Encouraging single partner relationships and main partner relationships also is a way to encourage disclosure. It may be most productive to encourage your patients to disclose prior to sexual relations.

One of the Partnership for Health flyers, "How to tell someone you have sex with that you have HIV" suggests ways that patients can disclose to a new partner. A sample of the flyer is included in the appendix of your Participant's Training Manual. Please see Module Six in the Participant's Manual for more about disclosure.

We recommend that you become familiar with the laws in your state about informing partners about the HIV status of your patient. We suggest that you seek legal counsel at your facility and at your local health department to set up procedures in your clinic and that you talk with patients about these procedures as well.

8) **If a busy medical provider can't cover all this information in one 3-5 minute session with a patient, what are the most important messages to focus on with patients?**
We don't expect the provider to cover all of the safer sex messages with a patient during each session. Providers need to open the dialogue with the patient so they can give messages and counseling appropriate for the problems the patient is encountering. Repetition over time is important to the success of this intervention as well as the provider building rapport with the patient over the course of their clinical relationship. With limited time, providers are encouraged to cover as many as possible of the three key PfH messages:

- Protect yourself
- Protect your partner
- Tell your sex partners about your HIV status

Section 5. Getting Started, Planning, Implementing and Maintaining PfH

In the following section, we review what a clinic needs to begin, implement and maintain the Partnership for Health.

5.1 Staffing (Please see Section 5.3, Cost to the Clinic)

- Coordinator. The Coordinator is responsible for "championing" PfH at the clinic. This involves a concerted effort during pre-implementation, implementation and maintenance of PfH. We recommend that this person be a staff member with the authority to make sure all aspects of the intervention occur as well as someone who knows the staff and how to motivate them to conduct the intervention. We recommend that the Coordinator be a physician assistant, research nurse, nurse practitioner, staff psychologist, or clinic administrator. Although the medical director may be a key leader in support of PfH, we do not recommend that this person assume the role and responsibilities of the Coordinator. The medical director often has multiple responsibilities and may not have enough time to pay attention to the details of coordinating PfH. We recommend that the Coordinator receive 50% salary coverage to coordinate this program through the Booster session and then 25% salary coverage thereafter to maintain the program. Please see Section 5.4 for specific details about Coordinator responsibilities.

- The PfH intervention is delivered by clinic health care providers, including physicians, physician assistants, nurse practitioners, registered nurses within the framework of the routine medical visit. PfH does not require additional staffing.

- Key Leaders. The Coordinator will want to consult clinic managers, medical directors and other site administrators when organizing Partnership for Health. In addition to these formal clinic leaders, the Coordinator may seek the support of informal leaders such as staff members who are respected by co-workers. The involvement of key leaders is very important although the leaders' overall time commitment to the project may be minimal.

- Consultants and On-going Technical Assistance. The clinic may need to identify psychologists or social workers to provide consultation to providers who encounter difficult patient situations that they are uncertain how to handle. Consultants can also provide on-going updates and in-service support on psychological/behavioral counseling models as well as consultation on needs assessments, referrals and ethical dilemmas.

5.2 Staff Training

- Orientation:
  The orientation will be conducted by the PfH trainer and the Coordinator. The orientation will be held 2-4 weeks before the training. The purpose of the orientation is to introduce staff and providers to the PfH program. This is a brief session attended by the entire clinic staff. (See Section 5.4 for more detail and Appendix D for sample orientation agenda.)

- **4½ hour clinic training:** The training will be conducted by the PfH trainer(s). The Coordinator may assist in the training. The purpose of the training is to prepare clinic providers and staff with the necessary skills to provide the PfH intervention to every patient at every clinic visit. (See Section 5.4 for more detail and Appendix D for sample training agenda and checklist.)

- **Booster session and in-services:** The first booster session occurs 4-6 weeks after the training and is conducted by the PfH trainer(s) and the Coordinator. Subsequent in-services may be developed and conducted by the Coordinator, other clinic staff, and may involve consultation with the TA Provider. These activities are an important part of maintaining PfH in your clinic. Booster sessions and in-services provide opportunities to refresh provider and clinic staff understanding of and skills related to PfH. It is also an opportunity to introduce topics related to the intervention. Topics may include: helping patients build safer sex skills and disclosure skills, updates on most utilized resources and referrals, and current research and best practices around prevention for HIV-positive patients. (See Appendix D for sample booster session agendas and materials.)

5.3 Cost to the clinic

Overall, few additional resources are needed to implement the PfH program in HIV clinics. PfH uses existing clinic staff and providers to integrate PfH into routine medical care.

- Coordinator: Although the On-site Coordinator is an existing staff member, it may be necessary to relieve the Coordinator of some of his or her clinic duties to accommodate the additional responsibilities associated with PfH. We suggest that the Coordinator allocate 50% time initially to facilitate the program, train new staff and lead discussions at staff meetings. This percentage of coordinator time can be reduced to 25% after the Booster session and for maintenance of the intervention. This time requirement could necessitate hiring additional clinic staff.
- Clinic staff (for example, front desk staff, medical assistants) provide support and reinforcement of the overall PfH theme although they are not responsible for discussing PfH messages with patients. For example, front desk staff can be responsible for giving brochures to patients when they check in for their visit.
- In addition, the issues of prevention in clinical care settings should be discussed regularly at staff meetings. Reviews of role plays, policy issues, difficult situations, and behavioral research may all be helpful.
- Providers discuss the PfH safer sex and disclosure messages with their patients at each clinic visit.
    - The actual intervention involves a 3- to 5-minute interaction between the primary care provider and the patient within the routine medical visit.
- Finally, staff release time will be required to attend the orientation, 4½ hour training and 1½ hour booster session.

The additional resources required to supplement the Coordinator's time and the release time for providers and clinic staff to attend training represent the major expense to the clinic for involvement in PfH. In some clinics, budget items, such as utilities, may be covered under clinic overhead. In other clinics these expenses are pro-rated by activity.

5.3.1 Sample PfH Budget

CATEGORIES	PRE-IMPLEMENTATION	IMPLEMENTATION
1. PERSONNEL • On-site Coordinator • Staff release time for training & booster sessions	# staff %time, # hrs/wk 1 50% 20 hrs wk all staff x 4½ hrs ea = hrs	# staff %time, # hrs/wk 1 25% 10 hrs wk all staff x 1½ hrs ea = hrs
2. FACILITIES • Rent–Office Space for Coordinator • Utilities • Maintenance • Rent–training space (if applicable)		
3. EQUIPMENT • Rental or purchase of equipment for training (laptop, LCD, overhead projector, TV/VCR or DVD player, easel) • Rental or purchase of computer (for Coordinator) • Internet service • Telephone/fax • Equipment Maintenance		

4. SUPPLIES
1. PRINTING & MEDIA:
• Intervention Pkg/Kit
• Duplication & binding of additional Participant's Manuals (from CD)
• Extra-large sheet protectors (back of manuals)
• Copying of flyers announcing training to staff
• Copying of Misc. handouts
• Copying of evaluation forms
• Duplication of posters (from CD):
5 large + small exam room posters in each set
• Duplication of additional brochures (from CD)
• Duplication of additional chart stickers (from CD)
	
	$200
	
	approx. 100 pp + 1½" D-ring binder x number of providers
	
	1 protector per manual/box of 25
	
	$ each x number of staff
	
	$ each x number of staff
	$ each x number of staff
	
	$ per large poster x 5 posters
	$ per small poster x no. exam rooms
	
	$ each brochure x number of patients
	
	$ each sticker x number of patients
		
		As needed
		
		As needed
		As needed
		
		As needed
		As needed
		
		As needed
		
		As needed

CATEGORIES	PRE-IMPLEMENTATION	IMPLEMENTATION
• Duplication & lamination of additional provider guides	$ each guide x number of providers	As needed
• Duplication of informational flyers	$ each x number of patients	As needed
• Certificates	$ each x number of providers	As needed
2. TRAINING SUPPLIES:		
• Carrying case for training supplies	$ each N" x N" x N" case	
• Transparencies	1 box/50	
• Easel charts	2 pads	
• Watercolor markers	2 sets of markers	
• Safer sex educational supplies (see Appendix D for suggested list of supplies)	$	Re-supply as needed
• Catering/refreshments	$ (or Donated) x number of providers	$ (or Donated) x number of providers
• Extra paper plates, cups, plasticware (for trainings and boosters)	$ x number of providers	
3. GENERAL OFFICE SUPPLIES:		
• Printer cartridges	2 cartridges	
• White copy paper	5 reams @ $ each = $	
• Colored copy paper	5 reams @ $ each = $	
• Pens & pencils	$	
• Postage & mailing	$	
• Items to remind Training Participants to do counseling (e.g, PfH logo coffee mugs)	$ (or Donated) x number of providers	$ (or Donated) x number of providers
6. TRAVEL		
• To/From training location (if off-site)	@ Current agency rate x number of providers	
• Facilitator		
• AETC		
• Orientation		
• Training		
• Booster		
7. CONSULTANTS		
• For additional Technical Assistance		
8. C.M.E. s		
• For set-up & on-going continuing education fees		

****As Needed Costs: Calculate based on the number of staff to be trained and patients served by the clinic.**

5.4 Integrating PfH in your HIV Care Clinic

Time Frame for Activity	Activity	Notes
2 – 3 months before orientation	**NOTE: Use your PfH Trainer! Your PfH trainer is an important resource. We strongly encourage you to use the trainer's assistance during all phases of PfH at your clinic.** **Pre-Implementation** **1A. Identify Coordinator** **(50% time initially; 25% time after Booster session)** **a.** Should be identified by clinic manager, medical director, and/or other person(s) with authority to reallocate job duties. **b.** Characteristics of the Coordinator: good working relationship with clinic providers and staff; good working knowledge of patients who receive care at the clinic; experience working with HIV patients as a primary care provider or psychosocial provider (e.g., social worker, psychologist, health educator); good organizational skills; viewed in a positive way by clinic providers and staff. **c.** We have found it is best to assign duties to a staff member who can be relieved of some duties so s/he can assume the Coordinator role. **d.** See Section 5.1, Staffing. **1B. Coordinator pre-implementation activities: Key Leaders** **a.** Identify key leaders who can support PfH (see Section 5.1, Staffing) Key leaders can be formal leaders (e.g., medical director, nursing supervisor) and informal leaders (e.g., staff who are admired by others, who can influence others) **b.** Meet with key leaders to discuss PfH **i.** Introduce PfH to them **ii.** Show the PfH introductory video **iii.** Talk about implementing PfH at the clinic, timeline. **iv.** Discuss appropriateness of PfH in your clinic a) Importance of prevention with persons living with HIV; b) Potential decrease in HIV transmission;	

Time Frame for Activity	Activity	Notes
	c) Effectiveness of PfH in reducing unsafe sexual behaviors among HIV patients receiving care; d) MMWR issue regarding prevention in primary care settings; e) Requirement of local AIDS Office for Ryan White funded clinic providers to discuss prevention with HIV positive patients. v. Describe assistance you may need from the key leaders a) Speaking in support of PfH at the orientation (see below); b) Working with the PfH trainers during the training; c) Updating or creating a resource list for patient referrals; d) Speaking at staff meetings; e) Keeping track of supplies; f) Applying for continuing education units for appropriate staff; g) Help coordinating periodic in-services following the training and booster; h) Help during the training (e.g., sign-in sheet, collecting evaluation forms, meeting the caterer & setting up for lunch or snacks) i) Help form a community advisory board (CAB) of key leaders and consult with them periodically about PfH. j) Anything else you want help with.	
Varies by institution or clinic	**1C. Coordinator pre-implementation activities:** **Preparing the clinic** a. Develop a timeline for PfH implementation, using suggested time frames in this table. b. Discuss timeline with key leaders and adjust as needed. c. Obtain approval for staff attendance at orientation, training, and booster from appropriate supervisors and directors.	

Time Frame for Activity	Activity	Notes
	i. Set approximate dates for orientation, training and booster (e.g., working around accreditation visits, other clinic activities). ii. Finalize these dates as soon as possible, get them into the clinic schedule, and notify staff so work calendars can be scheduled. iii. Reserve meeting space. **d.** Submit requests for approval of evaluation activities from your Institutional Review Board (IRB). This is very important (see Section 8). **e.** Obtain approvals for hanging posters in waiting room and exam rooms. **f.** Identify who will distribute brochures and informational flyers to patients. **g.** Determine how/if providers will note PfH discussion in the patient's chart. (See Section 8 regarding chart audits for evaluation.)	
2-4 weeks prior to training	**2. <u>Orientation</u>** **a.** Distribute flyers to all staff and providers. **b.** Hold the orientation meeting during a regularly scheduled all-staff meeting. **c.** Announce the orientation at various staff meetings (e.g., case managers, health educators, medical & nursing staff meetings) **d.** Confirm availability of meeting space and equipment. **e.** Attendance of your key leaders is very important. **f.** It is important that <u>all</u> staff attend. **g.** Bilingual and multi-lingual providers, staff and interpreters are especially important in clinics that serve patients who do not speak English. **h.** At orientation, the PfH trainer will take the lead. S/he will show orientation video, facilitate discussion, answer questions. You may want to talk with the trainer about your level of participation in the orientation.	

Time Frame for Activity	Activity	Notes
	i. Food is always well received at meetings. We recommend that you provide a snack for the orientation.	
2-4 weeks before training	**3. Preparation for Training** **a.** It is preferable to close the clinic for ½ day and train in one session. But if your clinic needs to train in multiple sessions, it is important that you schedule those trainings within 2 weeks of each other. **b.** Announce the training date(s) as far in advance as possible. **c.** Select a location that is suitable for training. Lighting, temperature, seating, adequate number of electrical outlets, are all important factors. **d.** Distribute flyers regarding the training to staff 2 weeks and 1 week prior to the training. **e.** Talk with your PfH trainer about what s/he will need for the training that you can provide. **i.** Discuss your role during the training. If you or any key leaders would like to participate in the training presentation, talk with the trainer about how you might do that. **ii.** Talk with your PfH trainer about arranging for food— snacks, lunch. If funds are limited, pharmaceutical representatives or local merchants may be able and willing to fund food.	
4½ hours	**4. <u>The PfH Training</u>** **a.** See Appendix D for training room set up & logistics. **b.** Prior to the training, confirm with your PfH trainer arrangements (e.g., equipment, meeting space, number of staff members and providers who will attend, food). **c.** The PfH trainer will take the lead during the training, with your assistance as agreed to earlier. **d.** Distribute flyers to all staff and providers. **e.** Announce the training at various staff meetings (e.g., case managers, health educators, medical & nursing staff meetings) **f.** Confirm availability of meeting space and equipment. **g.** Attendance of your key leaders is very important.	

Time Frame for Activity	Activity	Notes
	h. It is important that <u>all</u> staff attend. **i.** Bilingual and multi-lingual providers, staff and interpreters are especially important in clinics that serve patients who do not speak English. **j.** Food is an important part of the training. We recommend your provide a snack and lunch. **k.** See Participant's Manual for detail about the training.	
As soon as possible after the training	**<u>Implementation</u>** **5A. Prepare the clinic environment for PfH:** a. Begin distributing brochures to patients; b. Place posters in the waiting room and in exam rooms; c. Make a set of informational flyers available to each provider. Providers can refer to the flyers when talking with patients who have issues specifically addressed in a flyer; d. Be sure providers have the Provider Pocket Guide; e. If your clinic will document PfH prevention in the patient's medical chart, be sure procedures are in place for this (e.g., how Chart Sticker will be used, if medical record is electronic how chart stickers will be integrated). **5B. Send Reminders** **a.** Remind providers and staff--via email, flyers, announcements posted at work stations--of the day PfH begins in your clinic.	
4-6 weeks after the training	**<u>Maintenance</u>** **6A. Booster** **a.** Distribute flyers to all providers and staff with information about the booster: date, time, place, and what it's for. **b.** Confirm date and time with PfH trainer. **c.** Arrange for food. **d.** Confirm meeting space and equipment. **e.** PfH trainer will take the lead.	

Time Frame for Activity	Activity	Notes
	6B. In-service Trainings **a.** We recommend that you provide periodic in-services to clinic providers that address issues associated with PfH. **b.** You may want to use the informational flyers as topics, enlist questions from providers and staff, ask providers if there is an issue they would like to address. **c.** Put into place procedures for resupply of materials. **6C. Coordinator time can be reduced to 25% after initial booster.**	
Occurs during all phases of PfH Preimplementation, Orientation, Training, Implementation, Maintenance	**7. Evaluation** **a.** As noted above, you **MUST** obtain IRB approval before you ask any patients or providers questions for the evaluation. **b.** You also **MUST** adhere to HIPPA requirements before beginning evaluation activities. **c.** Evaluation is an important part of implementing a new program, identifying strengths and problem areas during the process of implementing the program will be key to your overall success. **d.** See Section 8, Evaluation and Quality Assurance for more information about this process.	

5.5 Commonly Asked Questions

1) How do we keep providers and staff motivated after the initial training?

It is important that clinic leadership communicate clearly that prevention for people living with HIV is an important priority. To that end, clinic leadership may adopt as standard of care Partnership for Health for all HIV positive patients. Integrate discussions of Partnership for Health into regular staff in-services, meetings and written communications. This may include speakers from local area agencies, AIDS service organizations, the county HIV epidemiology program.

2) What topics are good for booster sessions?

Topics may include communication skill building for providers to improve their discussions with patients about safer sex and disclosure; updates on most utilized resources and referrals; current research and best practices regarding prevention for HIV-positive patients. (See Participant's Manual, Section Booster Training.)

3) How can we best assess if the intervention/counseling is making a difference?

Remember that behavior change is gradual and incremental, so your patients' responses to the intervention/counseling are not likely to be immediate or dramatic. We also encourage clinic staff to discuss their experiences and to share information on challenges and successes that may occur in relation to the intervention. In addition, findings from your evaluation efforts can provide information about clinic practices.

Please be sure to follow your clinic or organization's protocol regarding appropriate human subjects' (IRB) approvals for interviewing patients and using patient medical records. See Section 8 of this guide.

4) What additional staffing will this take?

The clinic may need to hire a part-time On-site Coordinator. Please see Section 5.3, Cost to the Clinic.

5) Why does the clinic need an orientation?

Orientation assists with clinic readiness for PfH. In our previous work in the field, we found that the orientation helped to answer provider and staff questions about PfH prior to the actual training.

Section 6. Maximizing Cost Savings

Although no formal cost-effectiveness study of PfH was done, we can estimate savings in treatment costs for new infections averted. We can also estimate the cost of PfH counseling provided by medical providers in clinic settings. We use treatment cost estimates from Chesson (2004).

One syphilis infection averted: For example, let's consider one syphilis infection averted in a patient who practices safer sexual behaviors. Recent estimates for the treatment of syphilis are $444. Now let's look at the cost of prevention counseling using the PfH brief counseling model. If we estimate the provider hourly salary at $100 per hour, and estimate 5 minutes of safer sex counseling each month we find that prevention costs $8 a month. It would take 56 months of prevention counseling before we would reach the cost of treatment for one syphilis infection.

$444 treatment costs for one STD infection in an HIV-positive patient = 56 months of
$100 provider's hourly salary x .08 hours counseling per patient per month counseling

That's 4.6 years of monthly counseling to reach the point where the counseling costs as much as an STD treatment. Even if a counseled patient contracts an STD, counseling may have delayed acquisition of the infection and continued counseling may prevent or delay future STDs.

One HIV infection averted: Now let's consider each new HIV infection averted by an HIV-positive patient disclosing his/her serostatus, practicing safer sex, or both. The estimate for treating one HIV infection in Chesson et al. is $199,800. Assuming again, the provider's hourly salary is $100, and 5 minutes of counseling per month, PfH prevention counseling would cost $8 a month. It would take 24,975 months of prevention counseling before we would reach the cost of treatment for one HIV infection.

$$\frac{\$199{,}800 \text{ treatment costs for a new HIV infection}}{\$100 \text{ provider's hourly salary x } .08 \text{ hours counseling per month}}$$

$$= 24{,}975 \text{ months of counseling}$$

That's 2,081 years of counseling one HIV-infected patient every month before counseling costs as much as treating one new HIV infection.

Even if you needed to counsel ten patients to avert one syphilis infection, it would be 6 months before you approached the cost of treating one new infection. And, if it required counseling ten patients to avert one HIV infection, it would be 208 years before the cost of treating one new HIV infection was met.

6.1 Tips for increasing cost savings

- Counsel each patient at every visit using the brief PfH model
- Use appropriate internal resources (e.g., social workers, case managers, health educators) for patients whose issue require more time or in-depth counseling than you are able to provide
- Refer patients to appropriate external agencies that can provide in-depth counseling or other services you or your clinic are unable to provide.

Section 7. Adapting Partnership for Health

7.1 Fidelity

It is important to conduct an intervention with fidelity to its core elements. This means conducting and continuing the intervention by following exactly the core elements set by the research study that determined its effectiveness. In Section 4.3 we listed nine PfH core elements. As you prepare to implement PfH at your clinic/agency, you will need to keep in mind these nine core elements to assure adherence to them. When you evaluate the program, one thing you want to look at closely is fidelity, that is the extent to which your clinic applied all of the core elements to your implementation of PfH. We will talk about evaluation in Section 8.

7.2 Adaptation and Tailoring

Adaptation and tailoring are similar processes, though their purposes differ.

- **7.2.1 Adaptation of an intervention occurs when it is delivered in a different venue (where) or to a different population (who) than it was tested in during the original research.**
  As we stated earlier, PfH was designed for the HIV primary care clinic setting. There are other clinic settings that may want to adapt and integrate PfH into their settings for their HIV positive patients. For example, an Ob-Gyn clinic setting may need to adapt some of the PfH core elements to their particular setting for their patients who are HIV positive. In the Ob-Gyn example, both the "who" and the "where" differ from the "who" and "where" of the research. Similarly, the intervention may be adapted for use by outreach workers who work in the community setting as compared to those who provide health care in a clinic.

- **7.2.2 Tailoring occurs when the intervention is changed to deliver a new message (what), at a new time (when), or in a different manner (how).**

  As stated earlier in Section 3, the PfH research demonstrated that consequences frame messages are effective in reducing UAV among HIV positive persons who have two or more and/or casual partners or who have unsafe sex. The intervention messages will be tailored differently for females versus males, for those with one casual partner versus many casual partners, for those who also use drugs or alcohol and in other ways to meet the needs of diverse patients. Tailoring the intervention in this way changes the "how" of the message.

- **7.2.3** Let's talk about examples of adaptation and tailoring that may be carried out while maintaining fidelity to the core elements.

Core Element	Adaptation or tailoring
Providers deliver intervention to HIV positive patients in HIV outpatient clinics and agencies	Health care providers must deliver PfH to their patients, but a clinic may decide that other providers (e.g., case managers, health educators) may also discuss PfH issues with patients.
Prevention adopted as essential component of patient care	We recommend that clinics establish or revise clinic policy and procedure to make prevention an essential component of care. This includes policies that: allow for release time for training and continuing education related to prevention; staff in-service training and meetings that regularly have prevention education components; mentoring of new clinicians and staff emphasizing on-going , consistent prevention as a standard of care.
Using waiting room posters and brochures to reinforce PfH messages delivered by provider	PfH written materials create a visual theme in the clinic environment that supports the patient-provider partnership. • There may be circumstances when the use of the materials must be adapted. For example, some HIV clinics may be held a few days a week in a facility that houses other clinics (e.g., pediatrics, geriatric, oncology) during the remaining days. In this situation, the waiting room posters (which speak only to the partnership issue and do not mention HIV) could be appropriate for all patients. However, exam room posters, presenting consequences frame safer sex messages, would not be appropriate. This is when the plastic easel displaying the exam room poster could be set out on HIV clinic days and put away on the other clinic days. • Brochures may be used in a variety of ways: given to patients when they enter the clinic to read while waiting to be seen; used by providers to guide their PfH interactions with their patients.
Training all clinic staff, including support staff, to facilitate PfH integration into standard practice	We recommend that all staff be trained to PfH. • Training can be adapted so that only primary care providers participate in the role-playing exercises necessary to enhance their skills. • In settings other than HIV clinic settings, at a minimum, all health care providers should be trained, whether or not they currently care for HIV positive patients.

Core Element	Adaptation or tailoring
Building on the ongoing supportive relationship between patient and provider	This core element will be implemented in different ways depending on the provider's style and the patient's needs. • This core element is important to all patient-provider relationships, regardless of the patient's illness, and can be used in any medical setting.
During routine visits, provider initiated a 3-5 minutes discussion with patient about safer sex that focuses on self-protection, partner-protection, and disclosure	The 3-5 minute discussion will vary based on whether it is the first PfH discussion (when the PfH component of the visit may be closer to 5 minutes long) and on the time required for other medical issues. • At a minimum, it is important that the provider discuss one of the three core messages with every patient at each clinic visit.
Having provider use good communication techniques and use consequences frame message for patients engaged in high risk sexual behavior	Good communication techniques (such as being a good listener, being nonjudgmental, being trustworthy and informative) are important to building a positive provider-patient relationship. We expect that providers will learn and improve their communication skills during the PfH training and with materials provided in the Participant's Manual. • For patients who engage in high risk sexual behaviors consequences frame messages are essential core elements and cannot be tailored. • As noted above, PfH messages may be tailored for low risk or no risk patients by using the advantages frame.
Providing referrals for needs that require more extensive counseling and services	It is important that providers have access to a list of outside resources as well as names and numbers of in-house resources (e.g., social worker, case manager) to which they can refer patients whose issues require more time or expertise. • This support to the patient and provider is essential as more complex issues may be revealed through the PfH interaction.
Integrating prevention messages so that every patient is counseled at every visit	Repetition of message and reinforcement of behavior change at every visit are necessary PfH elements. • The only exception is for urgent care visits during which the patient is too ill to address the PfH messages.

7.3 Reinvention.

Reinvention means using PfH components in other ways. For example, providers may use the partnership approach and framed messages with HIV positive patients for other health issues, such as diet, exercise, medication adherence.

Another possibility for reinvention is that PfH may be used by prevention case managers. The reinvention has already occurred when PfH was implemented by an AIDS service organization (ASO) as part of the CDC Replicating Effective Programs project. Though this reinvention was not formally tested, the PfH model was enthusiastically adopted by this ASO. The case managers (nurse and social work) found the direct approach to discussing sexual behaviors with their clients was an effective way to initiate prevention discussions. They found their clients were willing to engage in the PfH discussion with them.

It is important to remember that these reinventions have not been tested and we do not know how effective these or other reinventions may be.

7.4 Commonly Asked Questions

1) **We need additional materials that specifically address unique or vulnerable populations at our clinic. What other materials has PfH already designed?**
PfH has developed eight informational flyers that address specific issues related to challenges paitent may face (e.g., "What if my sex partner refuses to use a condom?"). These flyers are in the Participant's Manual, Appendix A.

   As the HIV epidemic changes, new populations will emerge and materials will need to be developed for unique and vulnerable groups.

   We encourage you to talk with your PfH trainer / TA provider to assist you in developing materials about specific populations whose prevention needs are not addressed in the current PfH materials. This could include materials based on age, language, patient knowledge, risk factors, and other behaviors.

2) **How can we best create new materials based on the PfH philosophy?**
Although clinics may develop their own patient education materials to supplement the PfH package, we suggest the following to guide development.

- Use consequences frame message for persons with two or more and/or casual partners or who have unsafe sex.
- Use either frame for persons who are abstinent or practice safer sex with one main partner.
- Develop new materials that will support the patient-provider relationship.
- Use the three core risk reduction messages:
  - Protect yourself
  - Protect your partner
  - Disclose your HIV status appropriately

Section 8. Evaluation

8.1 Institutional Review Board Approval

When collecting data from persons in the context of an evaluation, it is essential that you communicate with your Institutional Review Board (IRB) to be certain you are in compliance with human subjects protection regulations. In addition, you must comply with HIPAA regulations. Whether you plan to interview patients or providers or conduct medical chart audits, you must submit an application to your IRB explaining your procedures and including your data collection forms. You must submit your application and receive approval **before** you begin data collection.

8.2 Process data

Process evaluation involves collecting and analyzing data about how the intervention is being delivered, whether it reaches the intended audience, and other issues of importance to the intervention.

When evaluating your program, you may want to answer specific questions to determine how effectively and with what fidelity your program is being implemented. The table below poses questions and lists the forms we have created for you to use. You may wish to ask additional questions and modify these forms, and we encourage you to make this evaluation useful for you.

Process to be evaluated: Question to be answered	**Data collection forms (The forms and instructions for their use are in Appendix C.)**
<u>Pre-implementation, Training, Implementation, Maintenance</u> 1. Are PfH Core Elements being implemented with fidelity? 2. Are PfH TA Guide and Participant's Manual useful? Accurate?	1. PfH Core Element Checklist 2. TA Guide & Participants Manual Quality
<u>Orientation/Training/Booster:</u> 1. Did all staff and providers attend the PfH orientation, training, booster, and inservices? 2. Did the training prepare providers with skills to conduct PfH?	1. PfH Orientation/Training/Booster Attendance Sheet 2. PfH Training Evaluation
<u>Implementation:</u> 1. What are provider attitudes and behaviors regarding PfH? 2. Are providers delivering the intervention? 3. Did PfH reach the intended audience?	1. Provider Survey (baseline) Follow-up Provider Survey (1, 3, 6 months) 2. Chart Audit 3. Patient Exit Survey
<u>Maintenance:</u> 1. Are PfH materials available and in use? 2. Have new staff been trained?	1. Maintenance Activities. On-site Coordinator Checklist 2. Staff Turnover

8.3 Process monitoring and evaluation

Process monitoring and evaluation are important to provide opportunities to assess program implementation and maintenance. We expect that clinics may adapt or tailor PfH to meet both clinic and patient needs. And we expect this to be done with fidelity to the nine PfH core elements.

The On-site Coordinator is commonly responsible for process monitoring and evaluation. Depending on the size of your clinic (e.g., the number of staff members, number of primary care providers, number of patients) you may choose to tabulate by hand responses to the items (for a small number of respondents) or to create a simple data base into which responses can be entered and frequencies easily tabulated (for a large number of respondents). Either way, the best way for you to monitor the implementation of PfH in your clinic and to evaluate the extent to which you are reaching your intended audience is to look at the numbers.

Though it is beyond the scope of this manual to provide you with further detail about evaluation, your TA provider may be able to provide you with technical assistance in this area.

8.4 Commonly Asked Questions

1) **Do we have to evaluate PfH?**
We strongly recommend evaluation because it can provide you with information you would not have without it. For example, chart audits can provide you with important information to document the delivery of prevention for positives to your funding agency. Chart audits provide you with "hard" numbers based on a systematic review of patient medical records, and this data is much more convincing than anecdotal information. Also, you may have a funder which requires some level of evaluation.

2) **Do we have to use all of these forms?**
We only recommend them. You can revise them to better meet your needs. They are a place to begin your evaluation.

3) **Must we interview patients?**
Interviewing patients can provide a direct assessment of patient experiences. In this case, you may want to know the patient's report about his/her interaction with the health care provider during that visit. It is possible to distribute an anonymous exit interview (like the Patient Exit Survey) that asks if counseling took place during that medical visit. It does not need to ask about patient sexual behavior.

However, to directly assess the impact of PfH on patient behavior, a clinic would need to conduct a baseline interview before program implementation and a follow-up interview 6 – 12 months later. Patients would need to be individually tracked so the baseline and follow-up interviews can be linked. This is beyond the scope of most clinics because it is expensive and requires adherence to complex research methods.

Section 9. Checklist of Appropriateness of PfH Intervention

After becoming familiar with the Partnership for Health, it is important that each clinic/agency review the following questions to determine whether this intervention is appropriate for the setting.

	Yes	No	May Be	Comments
1. Are PfH intervention goals appropriate for your clinic/agency?				
2. Are PfH intervention goals appropriate for your clinic/agency population?				
3. Are PfH intervention objectives appropriate for your clinic/agency (SMART--specific, measurable, appropriate, realistic)?				
4. Are PfH intervention objectives appropriate for your clinic/agency population ((SMART--specific, measurable, appropriate, realistic)?				
5. Are PfH risk reduction messages appropriate for your clinic/agency norms and values?				
6. Are PfH risk reduction messages appropriate for your clinic/agency population?				
7. Does your clinic/agency have the capacity to implement each core element?				
8. Does your clinic/agency have a governance commitment to implement each core element with fidelity?				
9. Does your clinic/agency have a management commitment to implement each core element with fidelity?				
10. Does your clinic/agency have staff commitment to implement each core element with fidelity?				
11. Does your clinic/agency have sufficient resources to implement each core element with fidelity?				
12. Are members of your clinic/agency population among those for whom the intervention was demonstrated to be effective?				
13. Is the PfH intervention culturally appropriate for your clinic/agency population?				
14. Does the PfH intervention address or have the capacity to address risk factors within your clinic/agency population?				

Section 10. Contact information

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A Brief Safer Sex Intervention For HIV Outpatient Clinics

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PLACE FOR TRAINER
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Appendix A.
Richardson, Jean L., et al. Effect of brief safer-sex counseling by medical providers to HIV-1 seropositive patients: a multi-clinic assessment. AIDS, 5/21/2004, 18:1-8.

Effect of brief safer-sex counseling by medical providers to HIV-1 seropositive patients: a multi-clinic assessment

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Objective: To test the efficacy of brief, safer-sex counseling by medical providers of HIV-positive patients during medical visits.

Setting: Six HIV clinics in California.

Design: Clinics were randomized to intervention arms evaluated with cohorts of randomly selected patients measured before and after the intervention.

Participants: Five-hundred and eighty-five HIV-positive persons, sexually active prior to enrollment.

Interventions: Prevention counseling from medical providers supplemented with written information. Two clinics used a gain-framed approach (positive consequences of safer-sex), two used a loss-frame approach (negative consequences of unsafe sex), and two were attention-control clinics (medication adherence). Interventions were given to all patients who attended the clinics.

Outcome measure: Self-reported unprotected anal or vaginal intercourse (UAV).

Results: Among participants who had two or more sex partners at baseline, UAV was reduced 38% ($P < 0.001$) among those who received the loss-frame intervention. UAV at follow-up was significantly lower in the loss-frame arm [odds ratio (OR), 0.42; 95% confidence interval (CI), 0.19–0.91; $P = 0.03$] compared with the control arm. Using generalized estimating equations (GEE) to adjust for clustering did not change the conclusions (OR, 0.34; 95% CI, 0.24–0.49; $P = 0.0001$). Similar results were obtained in participants with casual partners at baseline. No effects were seen in participants with only one partner or only a main partner at baseline. No significant changes were seen in the gain-frame arm.

Conclusions: Brief provider counseling emphasizing the negative consequences of unsafe sex can reduce HIV transmission behaviors in HIV-positive patients presenting with risky behavioral profiles.

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Introduction

A majority of persons diagnosed with HIV remain sexually active [1–6]. Many engage in safer sex, but some engage in unprotected sexual intercourse potentially contributing to the spread of the virus. Reports of the prevalence of unprotected anal intercourse ranges from 10% to 46% of HIV-positive men who have sex with men (MSM) [4,5,7–10]. The prevalence of unprotected vaginal intercourse in HIV-positive women ranges from 37% to 52% [11–13].

Most HIV prevention programs have been directed at HIV-negative persons [14–17]. Limited research has addressed reducing high-risk sexual behavior in HIV-infected persons despite their potentially important role in HIV transmission and their accessibility during medical care [18–19]. Counseling at the time of HIV testing sometimes does not address risk-reduction [20], is usually administered in a single short session at a time of high emotional distress and by a counselor without a sustained relationship with the seropositive person. Studies have shown that primary health care providers can help patients change risky health behaviors (e.g., smoking, diet) [21–23]. HIV care providers may be similarly successful in helping their HIV patients reduce risky sexual behaviors.

Information that instills recognition of risk and motivation to reduce risk can be conveyed in a way that emphasizes the benefits or positive consequences of protective behavior (gain-frame) or the risks or negative consequences of risky behavior (loss-frame) [24–26]. Although both can be delivered in a caring and concerned manner by the provider, these two frames may have a different impact depending upon the health care issue being addressed [24–27]. Loss-framed messages have done better than gain-framed messages in promoting detection behaviors (e.g., breast self-examination [25]), whereas gain-frame has done better than loss-frame in promoting prevention behaviors (e.g., use of sunscreen [27]). Prior studies, however, were not conducted in diseased persons who may be particularly receptive to messages about potential health risks. Also, framing information has not been examined in promoting safer-sex in HIV-positive persons and it is not clear which frame may be most efficacious.

We examined the efficacy of message framing in the context of a brief provider-administered, safer-sex intervention for HIV-positive persons in care. Messages were presented to patients in written form and by provider counseling during the patient's clinic visits.

Methods

Design

This was a controlled intervention trial performed at six large HIV clinics in California. Two clinics implemented gain-framed counseling (emphasizing the positive consequence of practicing safer sex), two clinics implemented loss-framed counseling (emphasizing the negative consequences of unsafe sex), and two clinics implemented an intervention to enhance adherence to antiretroviral therapy (ART) (attention-control). A measurement cohort was randomly recruited at each clinic during 1998–1999 and baseline data were collected. Providers and staff were trained to deliver the counseling intervention randomly assigned to their clinic. The intervention was delivered to all patients attending the clinic during a 10–11-month period during 1999–2000. The cohort was reassessed during a period up to 7 months after the intervention ended. An incentive was paid at each interview.

Procedures for the protection of human subjects were approved by the Institutional Review Boards overseeing each clinic and by the Institutional Review Board at the Centers for Disease Control and Prevention. A Certificate of Confidentiality was issued to all sites by the National Institute of Mental Health.

Participant selection criteria and recruitment

Trained project interviewers implemented standardized recruitment procedures. Criteria for inclusion in the measurement cohort included: being aware of one's HIV-positive status and sexually active (mutual masturbation, oral, anal, or vaginal sex) during 3 months prior to participation, age 18 years and older, fluent in English or Spanish, able to provide written informed consent, and intent to obtain care at the clinic for the next year. Enrollment continued until approximately 150 cohort patients were recruited at each clinic.

A total of 2027 patients were approached to determine eligibility. Nine percent ($n = 187$) refused to be screened and 562 were ineligible [not sexually active in the past 3 months (88.1%), not receiving regular care at the clinic (6.4%), diagnosed less than 3 months prior (6.2%), language or age exclusion (0.9%)]. Of the 1278 who were eligible, 886 (69%) enrolled and 392 were not recruited (46.7% lacked time, 10.0% refused, 39.0% no reason, and 4.3% other reasons). Each clinic sample closely approximated the composition of the clinic population in terms of gender and ethnicity.

The interviewer administered the questionnaire in a private room. To assure confidentiality and improve candor, the patient could record responses to the sexual

behavior questions on the questionnaire rather than answering aloud. The medical providers were not involved in collecting the data and were not aware of which patients were in the measurement cohort. The interviewer abstracted CD4 cell count and viral load from the patient's medical record. A randomly generated number was used to link waves and sources of data for each participant. At follow-up, the interviewer made at least 10 attempts to contact all patients who participated in the baseline survey.

Self-report measures

Measures focused on partner-specific sexual behaviors during the 3 months prior to the interview. Participants reported all sexual behaviors with up to two most recent partners in each of six partner categories: main partners, casual partners, and exchange partners by gender of partners. Participants used a checklist to report anal, vaginal, and oral sex with or without using a condom.

Intervention

A 4-hour training program was delivered to all clinic staff and consisted of: (i) background data and rationale; (ii) behavior change theories; (iii) communication skill building; (iv) conducting a brief counseling session and communicating gain- or loss-framed messages; (v) role play of safer-sex counseling; and (vi) program implementation and referrals. A booster training session was given 1 month after the start of the intervention.

The intervention ('Partnership for Health') emphasized the importance of a patient–provider team approach to help patients stay as healthy as possible. Providers discussed the partnership concept with patients and provided gain- or loss-framed messages (e.g., Gain: 'We encourage you to make choices that protect yourself and others. Safer sex protects you from other sexually transmitted diseases and from other strains of HIV;' Loss: 'We encourage you to make choices that do not put yourself or others at risk. Unsafe sex may expose you to other sexually transmitted diseases and other strains of HIV'). Providers also discussed safer-sex goals and risk-reduction behaviors. The counseling was brief (3–5 min) but was given at all visits except for those dealing with acute illness. Providers were asked to document counseling (not patient sexual behavior) in the patient's chart. The only aspect that systematically differed between clinics was the framing (gain versus loss) of the prevention messages and counseling delivered to patients. Similar information was included in printed material (e.g., a brochure given to all patients explained the partnership concept, and had a series of framed messages and risk-reduction strategies).

Attention-control intervention

The attention-control protocol focused on adherence to ART. The procedures and training for this protocol were similar to those used in the safer-sex interventions. It used the same types of counseling and materials as well as a tailored medication schedule.

Analysis

The primary outcome variable was self-reported unprotected insertive anal, receptive anal, or vaginal intercourse (UAV) with any partner(s) during the previous 3 months. A dichotomous score at baseline and follow-up was used (UAV with at least one partner versus no UAV with any partner). Logistic regression assessed the extent to which the gain- and loss-framed interventions (relative to the attention-control group) reduced UAV at follow-up after statistically controlling for covariates.

The arms differed significantly ($P < 0.05$) by ethnicity, income, employment, education, gender of sex partners, prevalence of UAV and number of sex partners in the past 3 months. The arms did not differ significantly on viral load, CD4 cell count, being on ART, years since testing HIV-positive, gender or age (Table 1). We included as covariates not only those variables that differed significantly by arm, but also those that were non-significant, thus controlling for potentially small confounding effects (see note at bottom of Tables 3 and 4).

Because randomization occurred at the clinic level, we repeated the analysis applying a generalized estimating equations (GEE) model to the data (PROC GENMOD SAS software, version 8.1). GEE adjusts for clustering of patients by clinic with simultaneous adjustment for patient covariates. We specified an exchangeable correlation matrix to indicate that each pair of patients in the same clinic was assumed to be correlated and the correlation remains the same for every pair of patients. Because the outcome was dichotomous, we specified the logit-link function.

We decided, *a priori*, to examine the intervention effects separately for those who had only one sex partner at baseline (lower-risk) and for those with two or more partners at baseline (higher-risk) to determine whether the interventions changed the behavior of persons most at risk for transmitting HIV.

Analyses were conducted to determine whether loss to follow-up of high-risk participants (i.e., those who engaged in UAV at baseline) was comparable across the three intervention arms. Analyses were also conducted to adjust for attrition. Those lost to follow-up were assigned a follow-up UAV score that was the same as their baseline score and analyses were repeated. This approach (last value carried forward), is a conservative imputation that assumes no intervention effect for those lost to follow-up [28,29].

Table 1. Comparisons on demographic, disease and risk characteristics at baseline by intervention group (n = 585).

	Control (%) (n = 196)	Gain-frame (%) (n = 175)	Loss-frame (%) (n = 214)	χ^2 (*P*)
Gender				
Female	13.8	14.9	13.1	0.25 (0.88)
Male	86.2	85.1	86.9	
Sexual orientation				
MSM	74.5	65.1	80.4	17.7 (0.007)
MSW	11.7	20.0	6.5	
WSM	12.2	13.7	11.7	
WSW	1.5	1.1	1.4	
Ethnicity				
African-American	8.1	21.1	17.8	26.3 (< 0.001)
Hispanic	38.8	44.0	30.4	
White	48.0	28.6	45.8	
Other	5.1	6.3	6.1	
Annual household income ($US)				
≤ 14 999	54.4	78.3	64.6	23.2 (< 0.001)
≥ 15 000	45.6	21.7	35.4	
Employment				
Full	35.2	17.7	17.7	23.1 (<0.001)
Part	18.9	19.4	22.0	
Not working	45.9	62.9	60.3	
Education				
Less than high school	21.9	34.3	15.4	27.3 (0.001)
High school graduate	20.9	26.3	21.0	
More than high school	57.1	39.4	63.6	
CD4 cell count ($\times 10^6$/l)[a]				
< 200	18.2	21.3	16.0	1.8 (0.41)
≥ 200	81.8	78.7	84.0	
Viral load (copies/ml)				
< 500	47.5	47.4	52.8	1.6 (0.46)
≥ 500	52.6	52.6	47.2	
On ART				
Not on ART	17.4	15.4	20.1	1.47 (0.48)
Yes on ART	82.7	84.6	79.9	
UAV				
No	68.9	71.1	58.8	7.63 (0.02)
Yes	31.1	28.9	41.2	
Number of sex partners				
One	67.4	74.9	57.0	13.9 (< 0.001)
Two or more	32.7	25.1	43.0	
Mean age (years)	39.1	38.6	37.8	$F = 1.54$ ($P = 0.21$)
Mean years since HIV-positive diagnosis	6.6	6.5	6.1	$F = 0.63$ ($P = 0.53$)

[a]CD4 cell count data is missing six values. MSM, Men who have sex with men; MSW, men who have sex with women; WSM, women who have sex with men; WSW, women who have sex with women; ART, antiretroviral therapy.

Results

We completed follow-up on 585 participants (66% of baseline sample). Of the 301 participants lost to follow-up, 114 (38%) could not be contacted, 58 (19%) were not seen at the clinic in 6 months, 43 (14%) moved, 27 (9%) died, 17 (6%) were incarcerated, 29 (9%) did not appear or refused, and 13 (5%) gave health reasons.

Those lost were similar to those interviewed at time 2 by gender, ethnicity, income, education, age, years since testing HIV-positive, CD4 cell count, number of sex partners in the past 3 months and past year, and prevalence of UAV. Those lost had a higher viral load, were less likely to be on ART, were more likely to be MSW, and were more likely to be at gain-frame clinics (due to the difficulty of following patients at one gain-frame clinic that served more transient patients). Most importantly, the prevalence of UAV at baseline in the loss (41%), gain (29%), and attention-control (31%) arms among the 585 longitudinal participants was comparable to the prevalence of UAV at baseline among the initial sample of 886 (44%, 31%, and 29%, respectively). This attrition analysis was repeated separately for participants who reported two or more sex partners at baseline and for participants who reported only one partner. Again, there was no evidence of differential loss in the three intervention arms.

On the follow-up survey, participants indicated how often their primary care providers at the clinic talked with them about safer-sex. After statistically controlling for responses to the same item at baseline, participants in the gain-framed [odds ratio (OR), 3.69; 95%

confidence interval (CI), 2.35–5.78; $P < 0.01$] and loss-framed (OR, 2.33; 95% CI, 1.46–3.73; $P < 0.05$) arms were more likely than participants in the attention-control arm to report that physicians talked with them about safer-sex at half or more of their clinic visits. The same pattern of results was obtained for safer-sex communication from a nurse, nurse practitioner, or physician assistant (assessed as a group). These findings indicate that the safer-sex counseling protocol lead to more frequent discussion of safer sex at gain- and loss-framed clinics in comparison to control clinics.

Table 2 displays the prevalence of UAV at baseline and follow-up, stratified by number of sex partners at baseline and by intervention arm. Among those with one partner at baseline, no significant change in UAV from baseline to follow-up was found in any of the intervention arms. Among those with two or more partners at baseline, UAV decreased 4% (Z, 0.23; $P = 0.82$) in the control arm, and increased a non-significant 10% (Z, 0.47; $P = 0.64$) in the gain-frame arm which may reflect nothing more than measurement error. In the loss-frame arm, however, UAV at follow-up was reduced by 38% from 53% to 33% (1–33/53; test of dependent proportions: Z, 3.13; $P < 0.001$). The reduction was comparable for sex partners reported to be HIV-negative/unknown (35% lower) and sex partners reported to be HIV-positive (32% lower). Analyses conducted separately for the two loss-frame clinics demonstrated that UAV was reduced at each clinic (46% and 30%). In summary, patients with one sexual partner at baseline were unaffected by the interventions, and the loss-frame intervention reduced UAV in patients with multiple sex partners at baseline.

Table 3 displays the logistic regression analysis of UAV at follow-up, comparing gain- and loss-frame arms against the control arm. Those with one partner at baseline were unaffected by the interventions. For those with two or more partners, UAV at follow-up was significantly reduced in the loss-frame arm compared to the attention-control arm (OR, 0.42; 95% CI, 0.21–0.83; $P = 0.01$) after controlling for UAV at baseline. The effect remained significant (OR, 0.42; 95% CI, 0.19–0.91; $P = 0.03$) in a multivariate model that controlled for all of the covariates. There was no significant effect for participants with two or more partners in the gain-frame arm.

Table 3. Logistic regression analysis of unprotected anal or vaginal intercourse (UAV) at time 2 by number of partners.

	Odds ratio	95% Confidence interval	*P*
Overall[a]			
Attention-control	1.0		
Gain-frame	0.96	0.60–1.54	0.88
Loss-frame	0.78	0.50–1.22	0.28
One baseline sex partner[a]			
Attention-control	1.0		
Gain-frame	1.18	0.65–2.17	0.59
Loss-frame	1.20	0.65–2.22	0.56
Two or more baseline sex partners[a]			
Attention-control	1.0		
Gain-frame	0.81	0.36–1.82	0.61
Loss-frame	0.42	0.21–0.83	0.01
Two or more baseline sex partners[b]			
Attention-control	1.0		
Gain-frame	1.37	0.50–3.74	0.54
Loss-frame	0.42	0.19–0.91	0.03

[a]Statistically controlling for UAV at baseline. [b]Statistically controlling for the following variables at baseline: UAV, age, ethnicity, education, gender of sex partners, income, employment, years since testing HIV-positive, CD4 cell count, viral load, and being under treatment with antiretroviral therapy.

At baseline, 45% of the MSM reported having two or more partners as compared to only 4% of heterosexuals (six individuals). We repeated the fully controlled analysis on MSM only and the results for the loss-frame effect were similar (OR, 0.43; 95% CI, 0.19–0.94; $P = 0.04$).

We re-examined the intervention for participants who had any casual/exchange partners at baseline (including those with one or two partners). A larger group of participants (n = 279) was included in this analysis because many of those with one partner considered that partner to be casual. UAV in the gain-frame arm was not significantly reduced (OR, 0.78; 95% CI,

Table 2. Percent unprotected anal or vaginal Intercourse (UAV) at baseline (time 1) and follow-up (time 2), by intervention arm and number of sex partners at baseline.

	Attention-control (n = 190)	Gain-frame (n = 172)[a]	Loss-frame (n = 210)[a]
One baseline sex partner			
Time 1	20% (25/127)	26% (33/128)	32% (38/118)
Time 2	21% (27/127)	26% (33/128)	28% (33/118)
Two or more baseline sex partners			
Time 1	54% (34/63)	39%(17/44)	53% (49/92)
Time 2	52% (33/63)	43% (19/44)	33% (30/92)

[a]The sample sizes of the intervention arms does not equal 585 due to deletion of homosexual women and a few cases of missing data.

0.41–1.52; $P = 0.47$), whereas UAV in the loss-frame arm was significantly reduced (OR, 0.51; 95% CI, 0.27–0.96; $P = 0.04$). There was no effect for those with only main partners at baseline in the gain-frame arm (OR, 1.27; 95% CI, 0.63–2.54; $P = 0.50$) or the loss-frame arm (OR, 1.31; 95% CI, 0.67–2.57; $P = 0.44$).

We repeated the analysis using GEE. Neither frame affected the prevalence of UAV for those with one partner. For those with two or more partners a significant reduction occurred in the loss-frame arm (OR, 0.34; 95% CI, 0.24–0.49; $P = 0.0001$) but no effect for the gain-frame arm (see Table 4). We also re-examined the intervention effects for those with casual/exchange partners using GEE. UAV was not changed in the gain-frame arm (OR, 1.21; 95% CI, 0.72–2.02; $P = 0.47$), whereas UAV in the loss-frame arm was significantly decreased (OR, 0.39; 95% CI, 0.26–0.59; $P = 0.0001$). These analyses are highly consistent with the individual-level analysis.

We conducted analyses for individual gain- and loss-frame clinics, although the reduced sample size diminished statistical power. In both loss-frame clinics a reduction in UAV at follow-up was found among those with multiple partners at baseline. Relative to attention-control clinics pooled, the odds were OR, 0.32 (95% CI, 0.14–0.71; $P = 0.005$) at one loss-frame clinic, and OR, 0.59 (95% CI, 0.25–1.41; $P = 0.24$) at the other loss-frame clinic. For the two gain-framed clinics, the odds were OR, 0.91 (95% CI, 0.29–2.87; $P = 0.87$) and OR, 0.76 (95% CI, 0.30–1.93; $P = 0.56$).

Our final analysis used imputed values of UAV to retain those lost to follow-up. We examined intervention effects for those with two or more partners at baseline after assuming no change in UAV (i.e., using the baseline score) in those lost to follow- up [28,29]. Using the full multivariate model we found that the reduction in UAV persisted (OR, 0.53; 95% CI, 0.26–1.06; $P = 0.07$) in the loss-frame arm compared to the control group.

Table 4. Generalized estimating equations[a] for unprotected anal or vaginal intercourse at time 2 by number of partners.

	Odds Ratio	95% Confidence interval	P
Overall[b]			
Attention-control	1.0		
Gain-frame	1.09	0.64–1.85	0.75
Loss-frame	0.70	0.40–1.24	0.22
One baseline sex partner[b]			
Attention-control	1.0		
Gain-frame	1.25	0.90–1.75	0.19
Loss-frame	1.13	0.83–1.54	0.44
Two or more baseline sex partners[b]			
Attention-control	1.0		
Gain-frame	1.19	0.73–1.94	0.50
Loss-frame	0.34	0.24–0.49	0.0001

[a]These models adjust for the effect of the clustering of patients by clinic. [b]Statistically controlling for the following variables at baseline: unprotected anal or vaginal intercourse, age, ethnicity, education, gender of sex partners, income, employment, years since testing HIV-positive, CD4 cell count, viral load, and being under treatment with antiretroviral therapy.

Discussion

This controlled intervention trial found that brief safer-sex counseling from primary care providers can be efficacious in reducing sexual behaviors that transmit HIV. HIV patients in medical care (estimated at 36–63% of adults with HIV infection in the USA) [30] may account for a significant fraction of HIV transmission. In spite of reduced infectivity of patients who are successfully treated with ART, [31,32] some patients fail treatment, [33] remain sexually active, [34] and potentially transmit HIV including drug resistant strains. Thus, widespread, sustained application of effective counseling could reduce HIV incidence in the USA where much of the HIV-infected population is under medical care.

The reduction of unsafe-sex in patients with initial risky profiles followed loss-, but not gain-framed interventions. There are solid conceptual grounds for explaining why the loss-frame intervention was efficacious. This may result from the differing immediacy and contingencies suggested by the two ways in which framing links risky behavior with outcomes. For patients engaged in risky behavior, the loss-frame message suggests 'your current behavior (unsafe-sex) could harm you or others' while the gain-frame message suggests 'changing your current behavior (switching to safer-sex) could protect you and others'. The loss-frame points out the potential serious consequences of the high-risk patient's current behavior, whereas the gain-frame addresses potential benefits of changed or idealized behavior. In addition, having HIV disease may predispose patients to think in terms of potential losses (e.g., 'I can get sicker,' 'I can infect others') thus enhancing their responsiveness to loss-framed messages [26]. Under conditions where patients have heightened concerns about their own health, loss-framed messages from a highly credible source such as one's health-care provider may strongly capture a patient's attention, increasing the extent to which the message is psychologically processed and acted upon. Whether combined gain- and loss-frame messages can change behavior as well is unclear.

The loss-frame intervention reduced unsafe sex in HIV patients with multiple or casual sex partners but not in

those with one partner at baseline. The latter participants had a much lower prevalence of UAV at intake, making it difficult for the interventions to reduce UAV further. Additionally, the intervention may have missed relationship-level factors (e.g., mutual discussion and agreement) necessary for behavioral change with steady partners. Counseling of couples may be needed to reduce sexual risk behavior in the context of a stable relationship [35]. Brief, loss-frame interventions may be most efficacious for patients who can change their behavior as an individual decision without need for discussion with a stable partner.

The failure of gain-frame interventions to change behavior could not be attributed to greater attrition or failure to deliver the intervention. However, smaller sample size (only 44 patients with multiple partners at baseline were available for follow-up in the gain-framed clinics) and pre-existing differences in their risky behavior (lower baseline prevalence of UAV at the gain-framed clinics) may have decreased the power to find an effect. Alternatively, emphasizing the positive consequences of safer behavior may not have had a strong psychological impact on those who are already HIV-infected. Additional research is necessary before conclusions can be reached about the efficacy of gain-framed messages in changing the sexual behaviors of HIV-positive persons.

These findings must be interpreted in the context of the limitations of the study. First, we cannot specify the source of the motivation for behavior change (self- or partner-protection, or both). Until this is clarified, counseling strategies should include both messages in order to address motivations that may vary across patients. Second, we cannot separate the contribution of written materials from the contribution of counseling from providers. Nevertheless, these components complement one another and are best conceptualized as an 'intervention package.' Third, because the intervention was evaluated with self-reports of sexual behavior biased reporting could have influenced the outcome, although our methodology attempted to minimize its effect. Moreover, our finding of an effect in only one of two arms strongly suggests that reporting bias was not a factor. Fourth, the loss-framed effect could depend on unique characteristics of the clinic or providers who delivered that intervention. This seems unlikely because reduction in UAV was observed in both loss-frame clinics. Although we do not know why the effect was somewhat larger in one clinic than the other, its consistency in two clinics is reassuring. Further, reductions in UAV were observed in the GEE model adjusting for clustering of patients by clinic. Finally, the reductions were observed only in participants with two or more partners at baseline (almost exclusively MSM). The small numbers of heterosexual men and women precluded separate analyses for these groups. Thus, our findings may apply only to behavioral change among MSM with multiple partners.

In summary, we have shown that counseling and messages that emphasize the risks or negative consequences of unsafe-sex can help reduce risky sexual behavior in HIV-positive patients with initially risky profiles. Brief provider-delivered safer-sex interventions are both feasible and effective at HIV clinics that serve a large number of patients. Additional research is needed to find ways to counsel those with one partner and, among those who are not currently sexually active, to maintain abstinence or safer sexual behavior in the future. Further refinement of interventions by tailoring the counseling to patient characteristics may also be beneficial.

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Appendix B. Understanding the Theory behind PfH.

B.1 Message-Framing and Behavior Change

- **Framing links a behavior with an outcome. Linking information, behavior, and outcomes is an important strategy to increase motivation.**

  When we talk about message framing, we are talking about linking a behavior with an outcome. Messages can be framed as either advantages frame or consequences frame. Consequences frame messages link a behavior with a negative outcome. Advantages frame messages link a behavior with a positive outcome.

  The PfH study was the first study to test health care message framing among people infected with HIV. In this study, consequences frame intervention messages were effective in reducing unsafe sexual behaviors among patients who had two or more and/or casual sex partners.

- How to Construct Consequences Frame Messages
  - Consequences frame messages
    - are realistic assessments of the results of risky behavior.
    - focus on a negative outcome of not doing a healthful behavior.
    - are not fear appeals.

  There are two ways to construct a **consequences** frame message:

  1. If you don't do this healthful activity, then something bad will happen.
     "If you don't use a condom, you may feel bad about yourself after having sex."

  2. If you don't do this healthful activity, then something good won't happen.
     "If you don't use a condom, you may not feel good about yourself after having sex."

  Many health care providers use consequences frame messages with their patients. For example, *"If you smoke, you could develop lung diseases."* Using consequences frame messages regarding safer sex may then be a natural way of communicating for a large number of health care providers.

- How to Construct Advantages Frame Messages
  - Advantages frame messages
    - focus on a positive outcome of adopting a healthful behavior.

  There are two ways to construct an **advantages** frame message:

  1. If you do this healthful activity, then something good will happen.
     "If you use a condom, you may feel better about yourself after having sex."

  2. If you do this healthful activity, then something bad won't happen.
     "If you use a condom, you avoid feeling guilty after having sex."

B.2 Stages of Behavior Change

We summarize below Stages of Change that may be helpful to health care providers when thinking about their patients' behavior change.

	What is it?	Safer Sex	Disclosure
Precontemplation	Not even thinking about the behavior or refusing to acknowledge that the behavior needs to be changed Possibly ignorant of the need for change.	"I don't think I can give HIV to someone else." "It doesn't matter if I get an STD. I already have the worse thing that can happen." "I enjoy sex without condoms."	"It is not my problem to bring up my HIV." "If they are HIV negative I am sure they will ask." "They must be positive."
Contemplation	Acknowledging the problem exists and considering changing the behavior in the future.	"I do need to be sure I don't get an STD. It would make it harder to treat my HIV."	"I do have a responsibility to tell someone before sex but it is very hard to do this."
Preparation	Making a plan or taking some steps to start the behavior.	"I am going to let my friends know that I am not going to get drunk at bars. It causes me to take risks. I am going to carry condoms also."	"I asked my friends who have HIV how they tell. I practiced in front of the mirror."
Action	Process of changing the behavior, perhaps doing it inconsistently. Trying to sustain their efforts	"I met someone and said that we needed to use protection when we had sex."	"I met someone and told him that I have HIV before we had sex."
Slip Ups	Slipping up and needing to restart the behavior or find other strategies	"I have no condoms." "I am tired of taking responsibility for other people." "I had sex without protection."	"I was lonely and got drunk and had sex with a stranger. I didn't talk at all about having HIV."
Maintenance	Doing the new behavior regularly, The behavior becomes a habit and can be maintained in challenging situations	"I have stopped having anal sex without protection. I am not sure what I am going to do about oral sex."	"I met three people this month that I wanted to have sex with. I told them all. Two of them left, but one stayed and we had sex with protection. It felt good to have it out in the open."

B.3 How can the provider use this information?

- Have realistic expectations for yourself and your patient.
- Remember that change takes time. Repeated messages over time help - moving someone further along is success even if it isn't a change to maintenance.
- Harm reduction is a good goal (less high risk sex, fewer partners, more condoms) even if the behavior is not 100% of what you would like to see.
- Realize that you, as a health professional, need the same things as your patients do; knowledge, skills, motivation, resources and support. Also, remember that adopting these new communication behaviors may take time to become a habit.
- Remember that a patient may be at a different stage for each of his/her risk behaviors.

Appendix C. Evaluation tools

These tools are meant to assist you in implementing and evaluating Partnership for Health in your clinic.

- **PfH Core Elements Qualitative Process Evaluation Tool**
- **Technical Assistance Guide and Participants Manual**
- **Quality PfH Orientation/Training/Booster Attendance Sheet**
- **PfH Training Evaluation**
- **Provider Survey**
- **Follow-up Provider Survey**
- **Chart Audits**
- **Self-Administered Patient Exit Interview**
- **Maintenance Activities**
- **Staff Turnover**

PfH Core Elements Qualitative Process Evaluation Tool
Pre-implementation, Training, Implementation and Maintenance

To be completed by On-site Coordinator

Listed below are the nine PfH Core Elements as outlined in the Technical Assistance Guide. We encourage you to review this with your PfH trainer/PfH TA provider at three points: pre-implementation, implementation, and maintenance. At each point, carefully consider each element and how it will be adapted or tailored, to meet the needs of your clinic as you maintain fidelity to the program core elements (See Section 7).

Check the time point of your review:

Today's Date _____

- □ Pre-Implementation
- □ Training
- □ Implementation
- □ Maintenance

Core Element	Adaptation or tailoring	How will this Core Element be implemented? Will it be adapted or tailored? If so, how?
Providers deliver intervention to HIV positive patients in HIV outpatient clinics and agencies	Health care providers must deliver PfH to their patients, but a clinic may decide that other providers (e.g., case managers, health educators) may also discuss PfH issues with patients.	
Prevention adopted as essential component of patient care	We recommend that clinics establish or revise clinic policy and procedure to make prevention an essential component of care. This includes policies that: allow for release time for training and continuing education related to prevention; staff in-service training and meetings that regularly have prevention education components; mentoring of new clinicians and staff emphasizing on-going , consistent prevention as a standard of care.	

Core Element	Adaptation or tailoring	How will this Core Element be implemented? Will it be adapted or tailored? If so, how?
Using waiting room posters and brochures to reinforce PfH messages delivered by provider	PfH written materials create a visual theme in the clinic environment that supports the patient-provider partnership. • There may be circumstances when the use of the materials must be adapted. For example, some HIV clinics may be held a few days a week in a facility that houses other clinics (e.g., pediatrics, geriatric, oncology) during the remaining days. In this situation, the waiting room posters (which speak only to the partnership issue and do not mention HIV) could be appropriate for all patients. However, exam room posters, presenting consequences frame safer sex messages, would not be appropriate. This is when the plastic easel displaying the exam room poster could be set out on HIV clinic days and put away on the other clinic days. • Brochures may be used in a variety of ways: given to patients when they enter the clinic to read while waiting to be seen; used by providers to guide their PfH interactions with their patients.	
Training all clinic staff, including support staff, to facilitate PfH integration into standard practice	We recommend that all staff be trained to PfH. • Training can be adapted so that only primary care providers participate in the role-playing exercises necessary to enhance their skills. In settings other than HIV clinic settings, at a minimum, all health care providers should be trained, whether or not they currently care for HIV positive	

Core Element	Adaptation or tailoring	How will this Core Element be implemented? Will it be adapted or tailored? If so, how?
	patients.	
Building on the ongoing supportive relationship between patient and provider	This core element will be implemented in different ways depending on the provider's style and the patient's needs. • This core element is important to all patient-provider relationships, regardless of the patient's illness, and can be used in any medical setting.	
During routine visits, provider initiated a 3-5 minutes discussion with patient about safer sex that focuses on self-protection, partner-protection, and disclosure	The 3-5 minute discussion will vary based on whether it is the first PfH discussion (when the PfH component of the visit may be closer to 5 minutes long) and on the time required for other medical issues. • At a minimum, it is important that the provider discuss one of the three core messages with every patient at each clinic visit.	

Core Element	Adaptation or tailoring	How will this Core Element be implemented? Will it be adapted or tailored? If so, how?
Having provider use good communication techniques and use consequences frame message for patients engaged in high risk sexual behavior	Good communication techniques such as (being a good listener, being nonjudgmental, being trustworthy and informative) are important to building a positive provider-patient relationship. We expect that providers will learn and improve their communication skills during the PfH training and with materials provided in the Participant's Manual. • For patients who engage in high risk sexual behaviors consequences frame messages are essential core elements and cannot be tailored. • As noted above, PfH messages may be tailored for low risk or no risk patients by using the advantages frame.	
Providing referrals for needs that require more extensive counseling and services	It is important that providers have access to a list of outside resources as well as names and numbers of in-house resources (e.g., social worker, case manager) to which they can refer patients whose issues require more time or expertise. • This support to the patient and provider is essential as more complex issues may be revealed through the PfH interaction.	
Integrating prevention messages so that every patient is counseled at every visit	Repetition of message and reinforcement of behavior change at every visit are necessary PfH elements. • The only exception is for urgent care visits during which the patient is too ill to address the PfH messages.	

Technical Assistance Guide and Participants Manual Quality
To be completed by On-site Coordinator

Activities during this quarter (check all that apply):

- ☐ **Pre-implementation**
- ☐ **Training/Implementation**
- ☐ **Maintenance**
- ☐ **Evaluation**

1. During the last quarter, how often did you use the PfH Participants Manual to help you implement or maintain the program?
   ___ Not at all
   ___ Less than once a month
   ___ A few times a month
   ___ About once a week
   ___ A few times a week
   ___ Almost every day

2. To what extent do you think the Participant's Manual accurately represents the following:

	Not at all accurately	Not very accurately	Somewhat accurately	Accurately	Very accurately	NA
a. Planning time needed to implement PfH						
b. Staff required to implement PfH						
c. Agency resources other than staff needed to implement PfH						
d. Agency resources needed to maintain PfH						

3. Please rate the Participant's Manual in the following regards:

	Poor	Fair	Good	Very Good	Excellent
a. Appropriateness for your clinic					
b. Clearly stated program objectives					
c. Clearly identified steps to implementation					
d. Clearly addressed potential barriers to implementation					
e. Easy to use style and format					
f. Other areas you would like to rate, particularly areas that could be improved.					

4. During the last quarter, how often did you use the PfH Technical Assistance Guide to help you implement or maintain the program?
   ___ Not at all
   ___ Less than once a month
   ___ A few times a month
   ___ About once a week
   ___ A few times a week
   ___ Almost every day

5. To what extent do you think the Technical Assistance Guide accurately represents the following:

	Not at all accurately	Not very accurately	Somewhat accurately	Accurately	Very accurately	NA
a. Planning time needed to implement PfH						
b. Staff required to implement PfH						
c. Agency resources other than staff needed to implement PfH						
d. Agency resources needed to maintain PfH						

6. Please rate the Technical Assistance Guide in the following regards:

	Poor	Fair	Good	Very Good	Excellent
a. Appropriateness for your clinic					
b. Clearly stated program objectives					
c. Clearly identified steps to implementation					
d. Clearly addressed potential barriers to implementation					
e. Easy to use style and format					
f. Other areas you would like to rate, particularly areas that could be improved.					

PfH Orientation/Training/Booster Attendance Sheet

Clinic name	
On-site PfH coordinator	
Date	
Trainers	
Activity type (mark one) ☐ Clinic Orientation ☐ 4.5 hour PfH training ☐ Booster session ☐ Inservice – Topic: _____ _____ _____	**Setting** (mark one) ☐ University HIV clinic ☐ Community HIV clinic ☐ County HIV clinic ☐ Veterans Administration HIV clinic ☐ Drug treatment ☐ AIDS service organization ☐ Community setting ☐ Correction/detention HIV clinic ☐ Other health care clinic ☐ Other – specify _____

Attendees

Name	Degree	Title

Name	Degree	Title

PfH Training Evaluation

To be Completed Day of Training by All Staff

Name (optional): _____ Date: _____

Position (circle one):

Medical Mental Health Health Education Admin

Other:_____

Instructions: Please rate your perception of your skills and abilities for the following items. If an item does not apply to your professional responsibilities mark N/A. There is no assumption that post-training ratings should necessarily be higher than pre-training ratings.

		Low	Med	High	NA
1. Your knowledge about prevalence of unsafe sex and disclosure among HIV+ populations	Before Training				
	After Training				
2. Your skill in initiating a discussion about disclosure with HIV+ patients.	Before Training				
	After Training				
3. Your ability to listen to the patient's perspective and respond to their needs in this area.	Before Training				
	After Training				
4. Your skill in initiating a discussion about safer sex with HIV+ patients.	Before Training				
	After Training				
5. How important do you feel it is to provide safer sex and disclosure counseling for HIV+ people	Before Training				
	After Training				

How useful was the manual in helping you to:

	Not useful at all	Not very useful	Some what useful	Useful	Very useful
6. ...Understand program objectives?	☐	☐	☐	☐	☐
7. ...Understand your role in PfH at your clinic?	☐	☐	☐	☐	☐
8. ...Learn how to talk with patients about safer sex and/or disclosure?	☐	☐	☐	☐	☐
9. How useful do you think the manual will be to you when you talk with your patients about safer sex and/or disclosure of their HIV status?	☐	☐	☐	☐	☐

General Information

10. What aspects of this program did you find most useful?

_____
_____
_____
_____
_____

11. What would you like to change or add to the program?

_____
_____
_____
_____
_____

12. Any other thoughts and feedback on this program?

_____
_____
_____
_____
_____

Provider Survey

Clinic___

This survey aims to assess the status of HIV counseling for patients at our clinic. Information obtained from this survey will help us better serve HIV infected patients and to prevent the spread of HIV. You will not receive payment for completing this questionnaire. Your responses to the items in this questionnaire will not jeopardize your employment at this clinic in any way. Although your name will not be used in any way, we do need specific information in order to link your responses to this survey to future surveys you may respond to.

Last 2 digits of your Social Security Number __ __

MONTH you were born (circle) **1 2 3 4 5 6 7 8 9 10 11 12**

Today's Date _____/_____/_____

1. **What is your gender?** ☐ **M** [1] ☐ **F** [2] ☐ **T** [3]

2. **Age** _____ years

3. **Ethnicity** ☐ **Caucasian** [1] ☐ **Hispanic** [2] ☐ **African American** [3]
☐ **Asian** [4] ☐ **Other** [5]

4. **Occupation:** ☐$_1$ **MD** ☐$_2$ **RN** ☐$_3$ **NP** ☐$_4$ **PA** ☐$_5$ **Pharmacist**
☐$_6$ **Case Manager** ☐$_7$ **Social Worker** ☐$_8$ **Health Educator**
☐$_9$ **Administration/staff** ☐$_{100}$ **Other**

5. **Are you a primary care provider?** ☐$_1$ **Yes** ☐$_2$ **No**

6. **How long have you been providing care to people living with HIV?** _____years

		0-20% of patients	21-40% of patients	41-60% of patients	61-80% of patients	81-100% of patients	Not Applicable
7.	In a given week, considering all of the patients you see (new & returning), what proportion do you ask if they are sexually active?	1	2	3	4	5	9
8.	What proportion of patients do you talk about safer sex with at their initial visit?	1	2	3	4	5	9
9.	In the absence of an STD, what proportion of patients do you discuss safer sex with?	1	2	3	4	5	9
10.	If your patient is abstinent, how often do you ask for clarification (e.g. ask them what they mean by or ask them how long they have been abstinent)?	1	2	3	4	5	9

Please circle the number that best reflects whether you agree or disagree with the following statements:

		Strongly agree	Slightly agree	Neither agree nor disagree	Slightly disagree	Strongly disagree	Not Applicable
11.	At staff meetings we discuss efforts to decrease unsafe sex among our patients	1	2	3	4	5	9
12.	My clinic has clear guidelines about counseling patients about safer-sex	1	2	3	4	5	9
13.	I don't have enough time to counsel my patients about safer sex	1	2	3	4	5	9
14.	I don't know how to talk with patients about safer sex	1	2	3	4	5	9
15.	I have a referral list to use for patients who engage in high risk sex	1	2	3	4	5	9
16.	I can refer patients who have psychosocial barriers to safer sex (e.g., substance use, domestic violence) to other providers with more time or experience than I have	1	2	3	4	5	9

Please circle the number that best reflects how often you counsel your patients concerning the following topics during the past three months:

		0-20% of visits	21-40% of visits	41-60% of visits	61-80% of visits	81-100% of visits	Not Applicable
17.	I counsel my sexually active patients about avoiding STD's	1	2	3	4	5	9
18.	I counsel my sexually active patients about avoiding other strains of HIV	1	2	3	4	5	9
19.	I counsel my sexually active patients about protecting the health of their partners	1	2	3	4	5	9
20.	I counsel my sexually active patients about disclosing their serostatus to their partners before sex	1	2	3	4	5	9
21.	I counsel my sexually active patients about reducing their number of partners	1	2	3	4	5	9
22.	I counsel my sexually active patients about alternative sex behaviors that have lower transmission risk	1	2	3	4	5	9
23.	I counsel my sexually active patients about condom use	1	2	3	4	5	9
24.	I counsel my sexually active patients about avoiding high risk places (e.g., bath houses)	1	2	3	4	5	9

How many patients with HIV did you see at this clinic during the past 5 working days? (Please estimate the total number, including new and return patients) _____

Of these patients in the past 5 days:

25. How many did you talk to about safer sex? _____

26. How many did you talk to about using condoms? _____

27. How many did you talk to about sexual behaviors that carry less risk than anal or vaginal intercourse (e.g., oral sex)? _____

28. How many did you talk to about informing their sex partners about their HIV positive status? _____

Follow-Up Provider Survey

Clinic _____

This survey aims to assess the status of HIV counseling for patients at our clinic. Information obtained from this survey will help us better serve HIV infected patients and to prevent the spread of HIV. You will not receive payment for completing this questionnaire. Your responses to the items in this questionnaire will not jeopardize your employment at this clinic in any way. Although your name will not be used in any way, we do need specific information in order to link your responses to this survey to future surveys you may respond to.

Last 2 digits of your Social Security Number __ __

MONTH you were born (circle) **1 2 3 4 5 6 7 8 9 10 11 12**

Today's Date _____/_____/_____

1. **What is your gender?** ☐ **M** [1] ☐ **F** [2] ☐ **T** [3]

2. **Age** _____ years

3. **Ethnicity** ☐ **Caucasian** [1] ☐ **Hispanic** [2] ☐ **African American** [3]
☐ **Asian** [4] ☐ **Other** [5]

4. **Occupation:** ☐1 **MD** ☐2 **RN** ☐3 **NP** ☐4 **PA** ☐5 **Pharmacist** ☐6 **Case Manager**
☐7 **Social Worker** ☐8 **Health Educator**
☐9 **Administration/staff** ☐10 **Other**

5. **Are you a primary care provider?** ☐1 **Yes** ☐2 **No**

6. **How long have you been providing care to people living with HIV?** _____years

		0-20% of patients	21-40% of patients	41-60% of patients	61-80% of patients	81-100% of patients	Not Applicable
7.	In a given week, considering all of the patients you see (new & returning), what proportion do you ask if they are sexually active?	1	2	3	4	5	9
8.	What proportion of patients do you talk about safer sex with at their initial visit?	1	2	3	4	5	9
9.	In the absence of an STD, what proportion of patients do you discuss safer sex with?	1	2	3	4	5	9
10.	If your patient is abstinent, how often do you ask for clarification (e.g. ask them what they mean by or ask them how long they have been abstinent)?	1	2	3	4	5	9

OVER =>

Please circle the number that best reflects whether you agree or disagree with the following statements:

		Strongly agree	Slightly agree	Neither agree nor disagree	Slightly disagree	Strongly disagree	Not Applicable
11.	At staff meetings we discuss efforts to decrease unsafe sex among our patients	1	2	3	4	5	9
12.	My clinic has clear guidelines about counseling patients about safer-sex	1	2	3	4	5	9
13.	I don't have enough time to counsel my patients about safer sex	1	2	3	4	5	9
14.	I don't know how to talk with patients about safer sex	1	2	3	4	5	9
15.	I have a referral list to use for patients who engage in high risk sex	1	2	3	4	5	9
16.	I can refer patients who have psychosocial barriers to safer sex (e.g., substance use, domestic violence) to other providers with more time or experience than I have	1	2	3	4	5	9

Please circle the number that best reflects how often you counsel your patients concerning the following topics during the past three months:

		0-20% of visits	21-40% of visits	41-60% of visits	61-80% of visits	81-100% of visits	Not Applicable
17.	I counsel my sexually active patients about avoiding STD's	1	2	3	4	5	9
18.	I counsel my sexually active patients about avoiding other strains of HIV	1	2	3	4	5	9
19.	I counsel my sexually active patients about protecting the health of their partners	1	2	3	4	5	9
20.	I counsel my sexually active patients about disclosing their serostatus to their partners before sex	1	2	3	4	5	9
21.	I counsel my sexually active patients about reducing their number of partners	1	2	3	4	5	9
22.	I counsel my sexually active patients about alternative sex behaviors that have lower transmission risk	1	2	3	4	5	9
23.	I counsel my sexually active patients about condom use	1	2	3	4	5	9
24.	I counsel my sexually active patients about avoiding high risk places (e.g., bath houses)	1	2	3	4	5	9

OVER =>

How many patients with HIV did you see at this clinic during the past 5 working days? (Please estimate the total number, including new and return patients) _____

Of these patients in the past 5 days:

25. How many did you talk to about safer sex? _____

26. How many did you talk to about using condoms? _____

27. How many did you talk to about sexual behaviors that carry less risk than anal or vaginal intercourse (e.g., oral sex)? _____

28. How many did you talk to about informing their sex partners about their HIV positive status? _____

29. To what extent have you found the Partnership for Health education materials (brochures, flyers, posters, pocket guides) useful in counseling your patients?

- ☐1 Not useful at all
- ☐2 Not very useful
- ☐3 Somewhat useful
- ☐4 Useful
- ☐5 Very useful

30. Approximately what proportion of your patients did you review the materials with at least once?

- ☐1 0%-20% of patients
- ☐2 21%-40% of patients
- ☐3 41%-60% of patients
- ☐4 61%-80% of patients
- ☐5 81%-100% of patients

31. Since Partnership for Health began, how often did you use the materials to counsel patients?

- ☐1 0%-20% of patients
- ☐2 21%-40% of patients
- ☐3 41%-60% of patients
- ☐4 61%-80% of patients
- ☐5 81%-100% of patients

OVER =>

Please circle the number that best reflects the extent to which you feel your Partnership for Health counseling **helped your patients** to change their following behaviors.

		Not at all helpful				Very helpful	Not Applicable
32.	Disclosure of serostatus	1	2	3	4	5	9
33.	Reducing number of partners	1	2	3	4	5	9
34.	Choosing less risky sexual behaviors	1	2	3	4	5	9
35.	Using condoms	1	2	3	4	5	9
36.	Avoiding high risk locations (raves, bars, etc)	1	2	3	4	5	9

37. To what extent do you feel the Partnership for Heath training prepared you to successfully implement the intervention counseling strategies?

- ☐1 Did not prepare me at all
- ☐2 Prepared me somewhat
- ☐3 Prepared me
- ☐4 Prepared me very well

38. In the future, if these materials were readily available, how likely would you be to incorporate use of the materials into your daily practice?

- ☐1 Not at all likely
- ☐2 Somewhat likely
- ☐3 Moderately likely
- ☐4 Very likely

Chart Audits
To be completed by On-site Coordinator

One way to measure provider performance is to conduct medical chart audits. If your clinic has decided to place the Chart Sticker or electronic record of counseling in each patient's medical record for every visit, then a periodic chart audit can provide you with an estimate of the extent to which providers discuss PfH prevention with their patients.

Chart audits can be labor intensive and your clinic may not have resources to devote to an extensive audit.

One way to approach this type of evaluation is a simple audit of medical charts for 10% of patients seen each day during one week. A 10% audit will provide you with a good estimate of (1) the proportion of providers who complete the PfH sticker, and (2) the proportion of patients who receive the intervention. We recommend a monthly chart audit during the first quarter and quarterly audits thereafter.

You may use this table or develop your own way of tabulating chart sticker documentation.

Audit week dates: _____	Mon	Tue	Wed	Thu	Fri	Total
Number of charts audited						
Number of PfH stickers completed – **PfH discussed**						
Number of PfH stickers completed – **PfH not discussed**						
Number of PfH stickers not completed						

Documentation of PfH in medical charts provides you with several options:

- You can evaluate the extent to which PfH is being delivered by providers to their patients.
- You can use your quarterly evaluations to provide feedback to providers and staff about clinic success with PfH.
- You can also provide documentation to funding sources of the clinic prevention for positives efforts.

Self-Administered Patient Exit Interview

Are you 18 years old or older? □ Yes – **Please continue.** □ No – **Please stop here. Thank you for your time.**
Did you come to the clinic today for a regular check-up appointment for your HIV or did you come because you felt sick or had an emergency? □ Regular check-up appointment – **Please continue.** □ Felt sick or had an emergency – **Please stop here. Thank you for your time.**

- We would like you to answer some questions on this form about your visit to the clinic today.
- Your participation is voluntary.
- If you decide not to participate, it will not affect your care at the clinic.
- Do not put your name on this form.
- Your answers to these questions will be anonymous, that means no one at the clinic will know you completed this form.
- It will take about 10 minutes for you to answer these questions.

1. How long have you been a patient at this clinic?
   - □ First clinic visit
   - □ Less than one month
   - □ One month to one year
   - □ One to five years
   - □ More than five years

2. How much time did you spend with your doctor today?
   - □ 0 – 5 minutes
   - □ 6 – 10 minutes
   - □ 11 - 15 minutes
   - □ 16 – 20 minutes
   - □ More than 20 minutes

3. Before today's visit, when was the last time you saw a doctor for a regular visit for HIV care?
   - □ Less than 3 months ago
   - □ 3 – 6 months ago
   - □ More than 6 months ago
   - □ This is my first visit to this clinic.

4. Today did your doctor answer all of your questions?
   yes □ no □

PLEASE TURN OVER →

5. Today did your doctor talk with you about:

a. safer sex	yes □	no □
b. using condoms	yes □	no □
c. anal sex	yes □	no □
d. vaginal sex	yes □	no □
e. protecting your partner	yes □	no □
f. limiting the number of people you have sex with	yes □	no □
d. sexual stimulation of yourself or your partner without the exchange of body fluids	yes □	no □
e. taking your medication	yes □	no □

6. How often does your doctor talk with you about sex and the people you have sex with?
   - □ Never
   - □ Some clinic visits
   - □ Half of clinic visits
   - □ Most clinic visits
   - □ Every clinic visit

7. How often does your doctor talk with you about you telling your sex partners about your HIV status?
   - □ Never
   - □ Some clinic visits
   - □ Half of clinic visits
   - □ Most clinic visits
   - □ Every clinic visit

8. In general, how comfortable **are you** when your doctor asks questions about:

	Very uncomfortable	Somewhat uncomfortable	Somewhat comfortable	Very comfortable	Don't talk about this
Your overall physical health	1	2	3	4	5
HIV-related symptoms you might be experiencing	1	2	3	4	5
Your sexual behavior	1	2	3	4	5
Your use of condoms during sexual intercourse	1	2	3	4	5
Problems taking your medications	1	2	3	4	5

9. How satisfied are you with the medical care you have received from this clinic?
   - □ Very satisfied
   - □ Somewhat satisfied
   - □ Somewhat dissatisfied
   - □ Very dissatisfied

10. Do the doctors and nurses treat you in a warm and friendly manner?
    - □ Very warm and friendly
    - □ Moderately warm and friendly
    - □ A little warm and friendly
    - □ Not at all warm and friendly

◇◇◇◇Thank you for completing this survey.◇◇◇

Maintenance Activities
On-site Coordinator Checklist

Today's Date _____

PfH Materials
□ Are PfH posters on the walls in the waiting room and each exam room?
□ Are PfH brochures available to the staff assigned to distribute them to patients?
□ Are PfH informational flyers available to staff assigned to distribute them to patients?
□ Does the clinic have an adequate supply of brochures & informational flyers?

Activities / Inservices
This is a list of possible activities to maintain provider and staff interest in PfH.

□ Distribute and discuss informational flyers during staff meetings
□ Discuss chart audit results. Focus on one area in need of improvement and one area of success.
□ Present one scene from training video and facilitate discussion about how to handle the situation.
□ Feedback regarding Provider Surveys.
□ Feedback regarding Patient Exit Surveys.

Would you like assistance from your PfH trainer to conduct other maintenance activities at your clinic? If so, what would be helpful?

_____
_____
_____

Are there particular issues or barriers to maintenance of PfH at your clinic? What are they? What are your ideas about how to resolve them? Would you like assistance to resolve them?

_____
_____
_____
_____
_____

Staff Turnover
To be completed by On-site Coordinator

Please indicate the number of staff who left (for any reason), the number of new staff hired, and number of new hires trained since your last assessment.

Today's Date _____

	Number who left	Number hired	Number new hires trained in PfH
Physicians			
Physician assistants			
Nurse practitioners			
Nurses			
Residents, medical students, interns			
Medical assistants			
Mental health staff (i.e., social workers, case managers, health educators)			
Support staff			

Did any PfH key leaders leave?

□ No □ Yes If yes, what were their clinic roles?

_____

Appendix D. Sample Orientation, Training and Booster Session Agendas and Materials

SAMPLE ORIENTATION SESSION AGENDA

Steps:

1. Call clinic and set up a time for an orientation – ask for 20 minutes. Mostly in conjunction with existing clinic meetings.
2. Offer CMEs/CEUs if possible
3. Conduct orientation.
4. Trainers/technical assistance providers and on-site coordinators should schedule brief meeting immediately after orientation session if possible to debrief and plan for training session.

Objective of orientation:

1. Introduce the PfH study and program.
2. Introduce the PfH team.
3. Get staff, providers and clinic leaders motivated and excited about the training and intervention.
4. Confirm training date, location, and logistics.
5. Answer questions.
6. After orientation meet with on-site coordinator to cover details of training and process evaluation.

PRESENTERS:

Trainers, site coordinator and site administrator

- Only 1-2 staff needed per orientation

TENTATIVE AGENDA:

1. **Overview and goals of the program (TRAINER)**
   - A. An HIV prevention program that works with people who are living with HIV to:
     - Decrease levels of unprotected sex they engage in and
     - Increase their disclosure of HIV to their sex partners.
   - B. The goal is to train providers and staff to initiate a 3-5 minute interaction with patients and emphasizes the importance of:
     - Self protection
     - Partner protection
     - Disclosure
   - C. Message is reinforced at each visit.

2. **History of the study (TRAINER)**
   - A. Began in 1998 as an NIH funded study.
     - 6 HIV outpatient clinics throughout CA
     - 9,000 patients enrolled at these 6 clinic
     - nearly 900 patients studied (approx 10%)
     - Patient/clinic demographics for study
     - 50,000 clinic visits
     - 75 primary care providers and support staff
   - B. Study results
     - Demographics of original study population
     - AIDS publication 2004
     - Messages showed to decrease unsafe sex (as self reported by patient) for those patients with casual and/or multiple partners.
     - Advantages vs. Consequences framed messages

- Significant reduction in unprotected anal and vaginal sex among patients in clinics using consequences frame messages

3. **What are elements of the intervention that set it apart from the other interventions for this population or other interventions of this type?**
   (TRAINER)
   A. Evidence based research
   B. Designed with and for HIV outpatient medical providers and staff
   C. Experience - conducted trainings since 1998
   D. Intervention is brief and made for clinic environment

4. **Brief overview of AHP process (SITE COORDINATOR)**
   A. Our philosophy on HIV prevention (e.g., not blaming persons living with HIV, prevention for positives should be part of a spectrum of prevention programming, etc.)

5. **What are the advantages (selling points) of the intervention?**
   (ON-SITE COORDINATOR AND/OR ADMINISTRATOR)
   A. This will help our patients get fewer STDs and not get other strains of HIV.
   B. This will help our patient's negative sex partners not get infected with HIV.
   C. This will improve patient/provider relationship.
   D. This will set our clinic apart as a model clinic and leader in the nation in terms of prevention for positives.

6. **Training summary (TRAINER)**
   A. Training is 4½ hours and we need everyone to be there
   B. Training is fun and informative. It's interactive and includes practical skill building and opportunities to talk about and practice doing the brief intervention with a variety of patients. We talk about specifics around sexual behaviors and patient terminology which is really useful.

7. **Your role is important (ON-SITE COORDINATOR AND/OR ADMINISTRATOR)**
   You are part of a new national diffusion project. You play a KEY role in modeling this program and it's implementation for your patients and clinic as well as other clinics and people living with HIV across the country.

8. **Final messages (TRAINER AND ADMINISTRATOR)**
   - Be sure to be at the training. Your attendance is VERY important.
   - We will have a booster where you can ask questions and give feedback once you have tried implementing it for a few weeks.
   - Thank you.

9. **Questions? (ALL as appropriate)**

10. **Distribute handouts on the following pages (ON-SITE COORDINATOR)**
    - **"Why Integrate PfH into Your Clinic?"**
    - **Flyer announcing date & time of clinic's training**
    - **AIDS PfH Study Abstract**
    - **PfH Program Summary (from CDC REP Website)**
    - **Brochures: English & Spanish (1 of each for each person)**
    - **Chart sticker (1 for each person)**

SAMPLE HANDOUT FOR ORIENTATION SESSION

Why integrate a Partnership for Health Program into YOUR HIV clinic?

Benefits to your clinic

- Opportunity to be a leader in the field of HIV prevention by implementing this well-respected, efficacious program.
- Opportunity to provide additional care to patients, which may set your clinic apart from others.
- Opportunity to implement a program that closely follows the CDC, HRSA, NIH, and HIV-MA recommendations for incorporating HIV prevention into the medical care of persons living with HIV (*MMWR* 2003;52(RR-12):1-23).

Benefits to health care providers

- Enhances provider role in improving patient's well-being and treating patient's disease.
- Enhances provider's ability to help his or her patients stay safe.
- Introduces the opportunity for the provider to help the patient understand that he or she can play an active role in stopping the epidemic.
- Expands HIV prevention expertise and practice.
- Enables the provider to make a significant contribution to the larger goal of reducing new infections of HIV in the community.
- Creates a closer relationship between the provider and his or her patients.

Benefits to patients

- Builds upon relationship with their health care provider.
- Helps the patient to stay healthy and helps their partner(s) to stay healthy.
- Expands opportunities to talk with and learn accurate information from a respected authority figure.
- Provides the opportunity to gain additional skills negotiating safer sex, using condoms, and disclosing their HIV status.
- Provides the opportunity to play an active role in stopping the epidemic.

In summary

The Partnership for Health Program provides your clinic with an easy to implement program that can positively impact your clinic, your patients and the community at large. On national, state and local levels, there is a growing acknowledgment of the need for HIV prevention programs for HIV positive individuals. Research has shown that the provider/patient relationship is significant and that brief counseling around HIV safer sex behaviors and disclosure can make a difference in terms of behavior change. The Partnership for Health program is created to be directly integrated into an existing HIV clinic environment. We look forward to joining you in implementing this important program. Please feel free to contact us for further information.

SAMPLE HANDOUT FOR ORIENTATION SESSION

Partnership for Health:

A Brief Safer-Sex Intervention for HIV Clinics

Date of Training
Time of Training

(Location & name of Hosting Organization or Clinic)

****

Mark your calendars—save the date!

Learn about safer sex and disclosure counseling in an interactive and fun atmosphere!

LUNCH PROVIDED

For questions call or e-mail:

(On-site Coordinator Telephone number and e-mail address)

SAMPLE HANDOUT FOR ORIENTATION SESSION

Keck School of Medicine of the University of Southern California
PARTNERSHIP FOR HEALTH PROGRAM
A Brief Safer Sex Intervention For HIV Outpatient Clinics

ABSTRACT

Context
Transmission of HIV may stem from sexual behaviors of persons aware they are HIV-positive, yet little attention has been given to prevention programs for this population.

Objective
To test the efficacy of brief, safer-sex counseling delivered by HIV primary care providers to patients during routine medical examinations.

Setting
Six large HIV specialty clinics in California between 1998-2001.

Design
Clinics were randomly allocated to different intervention arms evaluated with cohorts of randomly selected patients measured before and after the intervention.

Participants
585 HIV-positive persons, sexually active prior to enrollment, attending one of the six clinics (assessment cohort).

Interventions
All interventions included written information and communication from medical providers. Two clinics used advantages (gain) prevention messages/counseling (emphasizing positive consequences of safer sex), two clinics used consequences (loss) frame messages/counseling (emphasizing negative consequences of unsafe sex), and two clinics implemented an attention-control protocol (adherence to antiretroviral therapy). The interventions were given to all patients who attended the clinics during a 10-11 month period.

Main Outcome Measure
Self-reported unprotected anal or vaginal intercourse (UAV).

Results
Among participants who had two or more sex partners at baseline (almost all were gay or bisexual men), there was a 38% reduction ($P < .001$) in the prevalence of UAV among those who received the consequences (loss) frame intervention. No significant pre-post changes were observed in advantages (gain) frame or attention-control clinics. In participants with multiple partners at baseline, the likelihood of UAV at follow-up was significantly lower in the consequences (loss) frame arm (OR = .42; 95% CI =.19 - .91, $P = .03$) compared with the control arm after adjusting for baseline differences in UAV, demographic, and HIV-medical variables. Analyses were repeated using generalized estimating equations (GEE) to adjust for clustering and the conclusions did not change (OR=.34; 95% CI =.24-49, P=.0001). Similar results were also obtained in participants with casual partners at baseline. No effects were seen in participants who reported only 1 partner or only a main partner at baseline.

Conclusions
Brief provider counseling emphasizing negative consequences of unsafe sex can reduce HIV transmission behaviors in HIV+ gay and bisexual men presenting with risky behavioral profiles. The intervention can be integrated and sustained in a variety of primary care settings serving HIV patients.

SAMPLE HANDOUT FOR ORIENTATION SESSION

Partnership for Health: A Brief Safer-Sex Intervention in HIV Clinics

The Research

The Science Behind the Package

Partnership for Health (PfH) is a brief, provider-delivered, counseling program for individual men and women living with HIV/AIDS. The program is designed to improve patient-provider communication about safer sex, disclosure of serostatus, and HIV prevention. PfH is based on a Social Cognitive model that uses message framing, repetition and reinforcement to increase the patient's knowledge, skills, and motivations to practice safer sex.

Target Population

HIV-positive men and women

Intervention

At clinics providing primary medical care to HIV-positive persons, patients are given an informational flyer (in English or Spanish) at the front desk. Posters calling attention to the power of patient-provider teamwork are displayed in the waiting room. After the physical exam, the medical provider conducts the 3- to 5-minute counseling session. The provider delivers messages that focus on self-protection, partner protection, and disclosure. The provider frames the messages relative to the number and type of sex partners the patient has and whether the patient is practicing safe or unsafe sex. Consequences-framed messages emphasize a positive outcome that may be missed or a negative result that may occur when the patient engages in unsafe sexual behaviors or does not disclose their serostatus to their partners. Advantages-framed messages focus on a positive outcome that may happen or a negative result that may be avoided when the patient engages in safe sexual behaviors or discloses their serostatus to partners. The provider uses the brochures, informational flyers and posters in the examination room to facilitate counseling. The provider and patient identify behavioral goals for the patient to work on. The provider gives the patient referrals to services if any are needed. At follow-up visits, the provider inquires about the patient's progress on the behavioral goal, re-counsels the patient, and reinforces the patient's healthful behavior.

Research Results

Patients who had 2 or more sex partners or at least 1 casual partner and who received consequences-framed messages were significantly less likely to engage in unprotected anal or vaginal sex

For Details on the Research Design:

Effect of Brief Provider Safer-Sex Counseling of HIV-1 Seropositive Patients: A Multi-Clinic Assessment. JL Richardson, J Milam , A McCutchan , S Stoyanoff, R Bolan, J Weiss, C Kemper, RA Larsen, H Hollander, P Weismuller, CP Chou, G Marks (AIDS, 5/21/2004, 18: 1179-86.

SAMPLE HANDOUT FOR ORIENTATION SESSION

Partnership for Health: A Brief, Safer-Sex Intervention in HIV Clinics

The Intervention

A Package Developed from Science
Replicating Effective Programs (REP) is a CDC-initiated project that identifies HIV/AIDS prevention interventions with demonstrated evidence of effectiveness. REP supports the original researchers in developing a user-friendly package of materials designed for prevention providers. PfH is one of the REP interventions and is the product of extensive collaboration among researchers who originally developed and evaluated the intervention and the clinics and providers who implemented the intervention as well as patient focus groups. The package has been field tested in five clinics and one HIV prevention agency by non-research staff.

Core Elements
Core elements are intervention components that must be maintained without alteration to ensure program effectiveness. The core elements of Partnership for Health include:

- Having providers deliver the intervention to HIV-positive patients in HIV outpatient clinics..
- Having the clinic adopt prevention as an essential component of patient care.
- Training of all clinic staff to facilitate integration of the prevention counseling intervention into standard practice.
- Using waiting room posters and brochures to reinforce prevention messages delivered by the provider.
- Building on the ongoing supportive relationship between the patient and the provider
- During routine visits, having the provider initiate at least a 3- to 5-minute discussion with the patient or client about safer sex that focuses on self-protection, partner protection, and disclosure.
- Having the provider incorporate good communication techniques and use of consequences-framed messages for patients or clients engaged in high risk sexual behavior.
- Providing referrals for needs that require more extensive counseling and services.
- Integrating the prevention message into clinic visits so that every patient is counseled at every visit.

Package Contents

- A manual to guide clinics through planning, implementation, and maintenance of the intervention.
- Sample brochures, chart stickers, pocket counseling outline, posters, and flyers.
- A manual for each provider and a training video for each clinic

Intervention Orientation
All clinic staff attend a 4 ½ hour training and a 1-hour booster session in which they learn how to conduct the intervention, practice intervention delivery skills, and identify agency-specific implementation strategies.

Technical Assistance
Capacity-building assistance providers problem-solve with adopting agencies to achieve an effective balance between maintaining core elements and tailoring to local needs. Assistance providers address implementation concerns, answer questions, and provide advice.

Timeline for Availability
The package will be available from CDC along with training on program implementation and technical assistance in July 2004.

For More Information on the Partnership for Health Package:
Jean Richardson, DrPH or Maggie Hawkins, MPH, CHES at the Keck School of Medicine, University of Southern California, Department of Preventive Medicine and Institute for Prevention Research, 1441 Eastlake Avenue, Suite 3409, Los Angeles, CA 90089-9175. Phone 323-865-0343. jeanr@usc.edu or margareh@usc.edu

SAMPLE INITIAL CLINIC TRAINING AGENDA

Partnership For Health
BRIEF SAFER SEX COUNSELING WITHIN HIV OUTPATIENT CLINICS

HALF-DAY TRAINING AGENDA

10 minutes	***Sign in and complete provider survey***
10 minutes	Introduction, Ground Rules, Training Objectives (Module 1)
20 minutes	Powerpoint presentation on PfH Study & Program (Module 1)
10 minutes	Description of intervention materials & intervention flowchart (Module 1)
20 minutes	Behavior change theories and models applied to safer sex & disclosure (Module 2)
60 minutes	Communication skill building (Module 3)
15 minutes	BREAK
30 minutes	Conducting the brief counseling session (Module 4)
50 minutes	Patient Profiles and Role Plays (Module 5)
15 minutes	Final questions, discussion & evaluations

SAMPLE TRAINER'S AGENDA--CLINIC TRAINING

HALF-DAY TRAINING AGENDA (4½ hours) TRAINER'S VERSION

10 minutes	***Sign in and administer provider survey (Judson)***
10 minutes	Welcome (Jean) Introduction, Ground Rules, Training Objectives (Jony) (Module 1)
20 minutes	Powerpoint presentation on PfH Study & Program (Jean) (Module 1)
10 minutes	Description of intervention materials & intervention flowchart (Jean with help form Jony) (Module 1)
20 minutes	Behavior change theories and models applied to safer sex & disclosure (Jony) (Module 2)
60 minutes	Communication skill building (Module 3) (Jony – Patient's perspective – 15 minutes) (Jony & Jean – active listening & redirecting – 15 minutes) (Jean – framing section – 15 minutes) Jony – cocktail party -- 15 minutes)
15 minutes	BREAK
30 minutes	Conducting the brief counseling session (Module 4) (Jean)
50 minutes	Patient Profiles and Role Plays (Module 5) (Jony – sets up role plays. Tell people to use outline, brochure, sticker, and talking points as a guide.) Patient Profiles: 1 & 2 (Jony – Processes using the role play feedback form.)
15 minutes	Final questions, discussion & evaluations

CLINIC TRAINING TASKS & TIMELINE

Clinic site:
Location of training:
Coordinator meetings:
Orientation date:
Training date:
Booster date:
Trainers:

ACTIVITY	WHO	DATE DUE	DONE?
Set training dates & location	Trainer & On-site Coordinator		
Reserve training room	On-Site Coordinator/ Confirm with Trainer		
Select room and decide on seating layout *See hard copy of room layout picture & computer document on check-off sheet for room* Reserve equipment - LCD/ power point projector - TV/VCR unit - Overhead projector - Easels & Pads - Tables & chairs	Trainer & On-site Coordinator		
Take inventory of existing: ▪ Training manuals ▪ Supplies needed for training ▪ Videos ▪ Brochures ▪ Posters ▪ Stickers	On-site Coordinator & Trainer		
Order or buy supplies as needed (notebooks, dividers, disks, clear sleeves, etc.), Videos, Materials, safer sex supplies & prizes.	On-site Coordinator or Trainer		
Develop a list of all staff to be trained with their full contact information	On-site Coordinator		

ACTIVITY	WHO	DATE DUE	DONE?
Orientation	Trainer & On-site Coordinator		
Distribute more flyers about training to staff, esp. those who missed orientation	On-site Coordinator		
Contact pharmaceutical companies or local businesses re: donating lunch for training	On-site Coordinator		
Talk with Key Leaders if response is low to ask for their support to increase interest in the training & PfH	On-site Coordinator		
Send reminders to staff prior to training day	On-site Coordinator	▪ PHONE OR EMAIL ▪ Formal: ▪ Reminder:	
Send list of participants to Trainer prior to training date	On-site Coordinator		
Make copies of: ▪ Sign In Sheet ▪ Agendas ▪ Directions to site (if needed) ▪ Handouts for training ▪ Evaluations	On-site Coordinator/ Consult with Trainer		
PfH Materials: 1) Participant Manuals # 2) Chart Stickers # 3) Provider Guides 4) Posters (# of sets) ▪ Exam room ▪ Waiting room	Trainer w/ On-site Coordinator		
Training team meets to confirm roles, talk about where to meet, etc.	Trainers & On-site Coordinator		
Update and organize transparencies or PowerPoint slides	Trainer		
Organize training supplies	Trainer		
Pack for trip	Trainer		
Write out flip chart pads or put your notes on transparencies.	Trainer w/ On-site Coordinator		

TRAINING ROOM SET UP & LOGISTICS CHECKLIST

Training: _____
Number of people attending: _____
Location: _____
Parking: _____
Food provided by:
Sponsor's name and number: _____
Food place's name and number: _____
Time food is supposed to arrive: _____

	Item:	They have:	We need to bring
Need			
	LCD projector		
	Computer or Laptop		
	Connection cords and cables		
	Overhead projector (extra bulbs)		
	TV/VCR		
	Slide projector (extra bulbs)		
	Slide screen		
	Table to comfortably seat 20		
	25 chairs		
	Easel		
	Easel chart paper		
	Tables for food and coffee		
	Place for sign-in		
Find			
	Where are electrical outlets?		
	Where are bathrooms?		
	Where are telephones?		
	Nearest exits?		
	Temperature controls? Who do we contact to adjust the temperature?		
	Light controls?		
	Safe to leave items there on breaks?		
	Can we put up signs?		

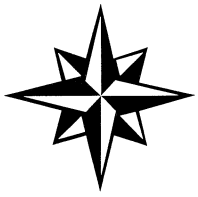
Sketch room layout on back of this page:

SAMPLE BOOSTER SESSION AGENDA

GOALS OF BOOSTER:

- Find out how providers are doing with the intervention; are they counseling patients? Are they giving Consequences frame messages? Do they need any help? Any questions came up that they couldn't answer?
- Find out what support they need. Address any problems that have come up.
- Review how to construct consequences frame messages.
- Review how to use the brochures and why.
- Discuss findings from the PfH research regarding Disclosure
- Discuss strategies for working with HIV-positive patients concerning serostatus disclosure to sex partners
- Review SAFER SEX TOOL BOX and strategies for discussing safer sex and harm reduction with patients

Partnership for Health Booster Session Agenda
(Location, Date & Time of Session)



Sign in
(10 minutes)

- **Participants complete Provider Surveys (follow-up version of initial survey)**

Welcome to the booster – our goals for today's mini workshop
(5 minutes)

Group discussion on how the Partnership for Health Program is going
(30 minutes)

Review Provider Counseling Outline & Review of Consequences Frame
(5 minutes)

Disclosure
(20 minutes)

Helping Patients Build Safer Sex Skills - ***Safer Sex Tool Box Demo***
(15 minutes)

Evaluations
(5 minutes)

PARTNERSHIP FOR HEALTH BOOSTER SESSION AGENDA: TRAINER'S VERSION *(LOCATION, DATE & TIME OF SESSION)*

Sign in
Compare who was there at initial training – give names of those absent to on-site coordinator to follow up with follow-up provider surveys.

Participants complete Provider Surveys (follow-up version) (10 minutes)

Introductions and welcome back (5 minutes)
Our goal for the booster is to talk about how the patient safer sex and disclosure counseling is going so far, review key aspects of the program and continue to build some skills around discussing disclosure and safer sex.

Discussion of their Partnership for Health Program (progress so far) (30 minutes)
By a show of hands, how many of you have spoken to your patients about safer sex and disclosure since the training?

How have your patients responded to you bringing it up? What feedback have you gotten from them (both negative and positive)?

Are you using the PfH materials? Which ones? Any feedback on them?

Posters in exam rooms	Posters in waiting room	Brochures (English/Spanish)
Chart Stickers	Informational flyers	Provider Pocket Guides

Have you adapted the program/counseling session in any way (from the way it was presented at the training)? If yes, how?

Now that you have been doing the counseling, looking back, is there anything else you would have wanted in the initial half day training that wasn't provided?

Is there anything (materials, training, support, etc.) that you need now to make this counseling program work better?

Review Provider Counseling Outline, Review of Consequences Frame (5 minutes)

Disclosure (20 minutes)

Helping Patients Build Safer Sex Skills - *Safer Sex Tool Box Demo* (15 minutes)

PAETC/PfH Evaluations (5 minutes)

SAMPLE HANDOUT FOR BOOSTER SESSION

Provider Brief Counseling Outline – Partnership for Health Program

The outline below covers the content of the brief counseling, however, the approach and style the provider uses is also very important. A provider who is approachable, caring, non-judgmental, and motivating can more easily build rapport with the patient. Good eye contact, body language and a friendly voice help to put the patient at ease.

1. **Explain what the Partnership for Health is.**

"The Partnership for Health is a program where healthcare providers and patients, like you and me, team up to keep you and your sex partners healthy. At our clinic, we are talking with all of our patients about safer sex. It is not easy to talk about sex, but it is important. I want to spend a few minutes talking with you about these issues, if that is OK with you."

2. **Ask one or two questions about your patient's sexual behaviors. Ask about problems they are having staying safe.**

A. Reinforce any protective behavior
B. Understand the problem presented and identify it for the patient

3. **Discuss some or all of the following three messages. Use consequences frame for high-risk patients.**

If patient is having unsafe sex or has many partners or casual partners use consequences frame	**If patient is completely safe with one partner or abstinent**
Protect yourself. *If you don't use a condom, you risk picking up other sexually transmitted infections.*	**Clarify what he or she means by safe or abstinent.** *So, then, you haven't had <u>any unprotected sex</u> including oral, anal or vaginal sex with anyone in the last three months?*
Protect your partner. *If you have many casual partners and don't use protection, they might get the virus from you.*	**Reinforce protective behavior.** *Not having any unprotected sex is a good way to protect yourself and others.*
Talk to all your sex partners about your HIV status. *If you don't tell your sex partner you have HIV and he or she finds out later or gets infected, it could be much worse.*	**Discuss what to do if he or she becomes sexually active in the future.** *If you meet someone and decide to have sex in the future, it's crucial to use condoms to protect you and your partner's health.*

4. **Set behavioral goal(s) with the patient or suggest some ideas if the patient cannot think of any.** Remember small goals are important steps to staying safe.
Make a notation in the chart that safer sex counseling was done and note the goals to review at the next clinic visit.

5. **Ask if there are questions and provide referrals if needed.**

6. **Deliver a supportive message, encouraging the patient to work on the goals and to check in with you at the next visit.**

SAMPLE HANDOUT FOR BOOSTER SESSION

PARTNERSHIP FOR HEALTH KEY COUNSELING POINTS

Protect yourself
Protect your partner
Talk to your partner(s) about your HIV status

Use Consequences Frame messages for patients with multiple (2 or more partners) and casual partners.

CONSEQUENCES FRAME REVIEW

Below are three safer sex/disclosure messages in advantages frame. Try changing them into consequences frame on your own. Check your answers below.

#1 Advantages: Having safer sex can keep you free from another strain of HIV that may be drug resistant and make your HIV harder to treat.

Consequences:

#2 Advantages: If you tell people you're having sex with that you have HIV, you're protecting them. Think of their families – kids, siblings, spouse, parents… Isn't that what you want to do?

Consequences:

#3 Advantages: Let's talk about some of the benefits of using condoms. If you use condoms, you reduce your risk of getting a sexually transmitted disease.

Consequences:

Answer key:

#1 Consequences: Not having safer sex puts you at risk for getting another strain of HIV that may be drug resistant and make your HIV harder to treat.

2 Consequences: If you don't tell people you're having sex with that you have HIV, you could infect them. Think of their families and all the people in their lives that would be hurt by that – kids, siblings, spouse, parents… Is that what you want to do?

#3 Consequences: Let's talk about some of the consequences of not using condoms. If you don't use condoms, you could get a sexually transmitted disease.

SUGGESTED SAFER SEX EDUCATIONAL SUPPLIES

Safer Sex Tool Box
The Safer Sex Tool Box is a handy resource to have in your clinic when you want to use visual models and provide hands-on learning on how to put condoms on, make oral sex barriers, etc. You may want to have one or two of these kits in your clinic to use as teaching tools or even a few items in each office (particularly the varied kinds of condoms and lube). We know that most people learn best by doing. Having a patient demonstrate the correct way to put a condom on a penis model and describe the best kinds of lubricant can be a helpful skill-building tool for patients who report condom breakage or who are unfamiliar with condom use.

Contents of the safer sex tool box:

- Container to hold all supplies (we use a tool box)
- Penis models (one light skinned color, one dark brown skinned color - depending on your clinic population, one wooden model and a plastic banana).
- Some patients are uncomfortable with the realistic models so you may prefer to use the wooden model or plastic banana. (Just be sure patients understand that the condom goes on the *penis* when they are actually having sex.)
- Assorted condoms in a variety of textures, sizes and colors
- Latex condoms: snugger fit, larger size (may be called "Max"), lubricated, (but not with nonoxynol-9), unlubricated, ribbed, studded, colored, flavored, mint, etc.
- Polyurethane condom
- Female condom (polyurethane)
- Sheer Glyde Dams® , cut non-lubricated condom, household plastic wrap
- Latex gloves and latex finger cots (for hands in vagina or anus)
- Lubricants that are safe to use with condoms; K-Y jelly, astroglide, etc.
- How to Use a Condom brochure in English and Spanish
- Pictures of sexually transmitted infections (STIs)

Places where you can purchase safer sex supplies for patient education:

Condoms and lubricants:	Local drug stores and supermarkets
Buying condoms and lubricants on the internet:	Most internet search engines can lead you to sites to purchase condoms, lube, information and all sorts of training tools to use when talking about safer sex.
Female condoms & female condom training video:	WWW.Femalehealth.com Some local stores may have female condoms or you can order them in bulk from the company. Their phone number is 1-800-635-0844.
Sheer Glyde Dams®	WWW.Sheerglydedams.com Latex dam approved by the FDA for protection against STDs during oral-vaginal and oral-anal sex.

"How to Use a Condom" brochure and pictures of Sexually Transmitted Infections (STIs):

Call your local health department to see what materials they have.

Condom companies may also have "How to use a condom" brochures in English and Spanish.

SAMPLE BOOSTER SESSION SET-UP AND LOGISTICS

Booster Training Session Materials & Supplies Checklist

Site:
Date:
Time:
Location: (include parking instructions)
Contacts:

ITEM **# NEEDED**

- **Trainer Notes & Agenda**
- **Maps & Directions to Site (for trainers)**
- **Sign In sheet**
- **Follow-up Provider Surveys**
- **Agenda**
- **Provider Outline and Framing Review Handout packet**
- **Disclosure Handout Packet**
- **AETC/PfH Training Evaluations (if applicable)**
- **Initial Provider Survey** *(as back-up copies only)*
- **Extra Manuals**
  - For those who missed original training:
  - Extra manuals for self-learning for any new staff:
- **Other Materials Needed for site**
  - Posters Waiting Room? List which & version:
    Exam Room? List version:
  - Chart Stickers
  - Brochures: English? #
    Spanish? #
  - Provider Guides
  - Patient Information Flyers (master copy)
  - Training Video
- **Do Program Record (AETC form) for site after workshop (if applicable)**
- **Instruct On-Site Coordinator about Self Learning if necessary**

MATERIALS & EQUIPMENT TO TAKE TO BOOSTER SESSION:

- Portable file box with all sign in sheets, directions, handouts
- Name tags
- Scissors
- Easel
- 1 set of watercolor markers
- masking tape
- extension cord
- overhead projector (depending on size of group)
- safer sex tool box (4 new condoms okay)
- flip chart
- write up the following on the easel chart sheets ahead of training (one sheet of paper per numbered item)

1. Patient Responses
2. Materials
    - Posters in Waiting Room?
    - Posters in Exam Room?
    - Brochures?
    - Informational Flyers?
    - Chart Stickers?
    - Provider Pocket Guides?
3. How have you adapted the intervention?
4. Additional training and/or materials you would like?
    - Initial training?
    - Now?

SAMPLE HANDOUT FOR BOOSTER SESSION ON *MAINTENANCE*

Keck School of Medicine of the University of Southern California
PARTNERSHIP FOR HEALTH PROGRAM
A Brief Safer Sex Intervention For HIV Outpatient Clinics

Maintaining Partnership for Health In Your Clinic

The Partnership for Health Program was originally designed to be easily integrated into standard HIV outpatient clinic practice. This translates into activities and materials that can be readily incorporated into the care that providers and staff normally give to patients.

Here are a few suggestions as to how you can maintain PfH in your clinic:

1) **Make Prevention for HIV Positive People a Standard of Care**
   - Providers and staff need to clearly understand that prevention for positives is a high priority at your agency.
   - Clinics can create policy to adopt intervention as a standard of care.

2) **Administrative Support**
   - PfH is most successful when clinic administrators provide on-going support for the intervention and continuing education for clinic providers and staff around prevention for HIV positive patients.
   - Support translates into:
     i. Making prevention for positives during standard clinical care clinic policy
     ii. Continued release time for orientation, training, inservices and updates for providers and staff
     iii. Funding for materials and activities associated with PfH
     iv. Continued willingness and ability to use PfH materials:
       - Can this clinic realistically put up, distribute and continue to distribute PfH posters, brochures and informational flyers?
       - Are these materials usable for both the providers and the patients? (Appropriate skill level? Appropriate language, culture & class sensitivity? Appropriate literacy level?)
       - Have the materials available in different formats (smaller posters, larger type, etc.) most like to be used by this clinic. All materials should have same design, however, to keep a strong association w/PfH.

3) **On-site Coordinator**
   - Clinics maintain PfH better when one staff member has a portion of their time devoted to organizing and continuing the intervention. It is generally best that the on-site coordinator be someone who knows the staff and clinic well and has the ability to navigate the clinic administration should problems arise.
   - Coordinator should have the ability to schedule any orientations, trainings and/or booster sessions for the project as necessary. This includes continuing education or updates on prevention for people who are HIV positive.

- Coordinator should have the ability to organize and assist with quality assurance measures, e.g. chart audits to insure that providers are counseling patients, patient surveys. This could include assisting in the establishment of policy emphasizing PfH as a standard of patient care.

4) **Maintaining Quality Care**
   - Integrate discussions of prevention for positives into regular staff inservices, meetings and agency communications.
   - Encourage clinic staff to discuss their experiences and to share information on challenges and successes that may occur in relation to the intervention.
   - Speakers from local area referrals and resources who will help providers increase their knowledge and skills around topics associated with prevention.
   - The site coordinator may choose to conduct regular chart audits and share the results with providers and staff regarding provider counseling and any observable differences in patient behavior change. As with the sharing of any client information, HIPAA guidelines should be observed.
   - Client surveys can also provide the agency with additional information about the success or problem areas of the intervention. As with the sharing of any client information, HIPAA guidelines should be observed.
   - Please be sure to follow your clinic or organization's protocol regarding appropriate human subjects' (IRB) approvals for interviewing patients and using patient medical records.

5) **Other Ideas to Motivate Providers:**
   - Documentation can be used to support Ryan White funding requirements
   - Infectious Diseases Society of America (IDSA) guidelines now support Prevention for Positives integrated into clinical care; *see CDC MMWR, July 18, 2003.*
   - Add monitoring of provider counseling to clinic's Quality Assurance measures.
   - Obtain and integrate into PfH role plays into staff inservices. The On-Site coordinator needs to take responsibility for making sure this task is done on a regular basis for provider/staff skill building.
   - Set aside 20 minutes per month at regular inservices or meeting to discuss topics related to prevention of positives.
   - Some suggested topics for inservices: communication skill building around safer sex and disclosure, updates on most utilized resources and referrals, current research and best practices around prevention for HIV-positive patients. *See section in PfH Participant's manual on "Conducting Booster Training Sessions" for additional suggestions.*

Appendix E. Glossary

Advantages Frame	Advantages frame messages link a behavior with a positive outcome.
AETC	AIDS Education and Training Center
AHP	Advancing HIV Prevention Initiative. CDC project to disseminate HIV prevention interventions that have been scientifically tested and found to be effective.
Consequences Frame	Consequences frame messages link a behavior with a negative outcome.
Message Framing	Message Framing (derived from Prospect Theory) is a behavior change theory that states that messages can be framed in loss frame (consequences frame) or gain frame (advantages frame). The effectiveness of a particular frame depends upon several factors, including the patient's psychological state, the patient's health status, the behavior in question. Please see the Rothman and Salovey citation in the reference section if you would like more detailed information about message framing theory.
REP	Replicating Effective Programs, CDC project to convert the protocols of HIV prevention interventions, which have been scientifically tested and found to be effective, into materials that clinics/agencies can use to implement the intervention themselves.
Stages of Change	A theory of behavior change that emphasizes the incremental, gradual process of behavior change. Please see the Prochaska citation in the reference section if you would like more detailed information about Stages of Change theory.
TA	Technical Assistance

Appendix F. References

Chesson HW, Blandford JM, Gift TL, et al. The estimated direct medical cost of sexually transmitted diseases among American youth, 2000. Perspectives on Sexual and Reproductive Health, 2004, 36(1): 11-19.

Centers for Disease Control and Prevention. Incorporating HIV prevention into the medical care of persons living with HIV: Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR 2003; 52.

Rothman AJ, Salovey P. Shaping perceptions to motivate health behavior: The role of message framing. Psychology Bulletin, 1997, 121:3-19.

The Partnership for Health intervention promotes the Centers for Disease Control and Prevention Advancing HIV Prevention Initiative. Partnership for Health addresses integrating HIV prevention into medical care settings for persons living with HIV/AIDS.